

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 15 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace Ellen Aber		4. DATE OF DEATH Month Day Year 5 20 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/83
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Indiana, USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton Quyle		14. MOTHER'S MAIDEN NAME Susan Chowning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 420.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pneumonia, left lung; atrial fibrillation.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/5/61 to 5/20/61 , that (I) (we) last saw the deceased alive on 5/5/61 , and that death occurred at 5/20/61 M, from the causes and on the date stated above.			
22a. SIGNATURE G.F. Meadors, M.D.		22b. DATE SIGNED 5/20/61	
22c. PHYSICIAN'S NAME (Type) G.F. Meadors, M.D.		22d. ADDRESS Main Street, Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 22, 1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR MAY 25 '61	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

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File not in

• *Abstracts* Section

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FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5723

06870

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring seven years c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 192 Fleetwood Terrace				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland Montgomery b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 192 Fleetwood Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Edward Ackerman Jr.				4. DATE OF DEATH Month May Day 31 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1889	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Budget & Fiscal officer				10b. KIND OF BUSINESS OR INDUSTRY HG. U.S.A.F.		11. BIRTHPLACE (State or foreign country) Peekskill New York	
13. FATHER'S NAME Charles Edward Ackerman, Sr., New York				14. MOTHER'S MAIDEN NAME Catherine Braceling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW2				16. SOCIAL SECURITY NO. 215-26-3654		17. INFORMANT Mr. Charles E. Ackerman, 1913 Eries St. W. Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Pulmonary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emphysema (c) Cor pulmonale				INTERVAL BETWEEN ONSET AND DEATH Four and a half years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6-1-61			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/61		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or country) (State) Arlington County, Virginia	
23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Avenue Raymond A. Ziska Silver Spring, Maryland				24a. REC'D BY REGISTRAR JUN 7 '61		24b. REGISTRAR'S SIGNATURE Charles E. Hines	

MEDICAL CERTIFICATION

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>21 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>Rt #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Peggy</u> First <u>N</u> Middle <u>Adams</u> Last					4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1961</u>														
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/10/7/1922</u>		9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Thomas Hamilton</u>					14. MOTHER'S MAIDEN NAME <u>Bertha Mosley</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>?</u>					17. INFORMANT <u>Heroy Adams (husband)</u> Address <u>same</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Perforated Gastric Ulcer</u> (a), stating the underlying cause last, (c) <u>CARCINOMA, stomach</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>2mo</u> <u>9mo</u>															INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>			Month, Day, Year <u> </u> <u> </u> <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> <u>1961</u> to <u>5-17</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> <u>1961</u> , and that death occurred at <u>6:49 A.M.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>J. Roscoe Creeper M.D.</u>					22b. DATE SIGNED					22c. PHYSICIAN'S NAME (Type) <u>J. Roscoe Creeper</u>					22d. ADDRESS <u>1800 Eye St. N.W. Wash. 6 D.C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>SHIPPED</u>					23b. DATE THEREOF <u>5/22/61</u>					23c. NAME OF CEMETERY OR CREMATORY <u>THOMPSON & CARPENTER FUN.</u>					23d. LOCATION (City, town or county) (State) <u>HOME, SPARTANBURG, S. C.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>					ADDRESS <u>ROCKVILLE, MD.</u>					25a. REC'D BY REGISTRAR <u>MAY 24 '61</u>					25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				

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THOMPSON & COMPANY, NEW YORK

5/53/01

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REVIEWS

TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5725

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN lb <i>1 month</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitation Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> d. STREET ADDRESS <i>7113 Poplar Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Charles A. Alexander</i>		4. DATE OF DEATH Month <i>May</i> Day <i>16</i> Year <i>1961</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-1-78</i>	9. AGE (In years last birthday) <i>83</i> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Paper Products</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Hungary</i>			
12. CITIZEN OF WHAT COUNTRY? <i>America</i>		13. FATHER'S NAME <i>Sigmond Alexander</i>		14. MOTHER'S MAIDEN NAME <i>Helen (unknown)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>SON-IN-LAW</i> Address <i>Mt Marty Gettleman 7113 Poplar Ave. Takoma Park</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>6000</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Uremia</i> cause last. (c) <i>Pyelonephritis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i> <i>5+ yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Diabetes mellitus; Paget's Disease of Bone</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>4/1/61</i> to <i>May 16</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>May 16</i> , 19 <i>61</i> , and that death occurred about <i>8:00 P.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Norman H. Rubenstein</i>		22b. DATE SIGNED <i>5/17/61</i>					
22c. PHYSICIAN'S NAME (Type) <i>NORMAN H. RUBENSTEIN</i>		22d. ADDRESS <i>6480 N.H. Ave. Takoma Park, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 19, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rabbi Isaac Elchovan Cem.</i>			
23d. LOCATION (City, town or county)		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		24b. ADDRESS <i>4207-92 20th</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 18 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

VR A15 (4)
15M 9/60

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Small
Budgetary

1897-1898: 1st Year of 1897

9413

16 JAN 1981

Wm. H. Thayer

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• www.pearsoned.com

Index

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5726

45714

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Erie</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Erie</u> d. STREET ADDRESS <u>533 Shenley Drive</u>											
3. NAME OF DECEASED (Type or print) <u>Mildred Marie Anderson</u>				4. DATE OF DEATH Month <u>5</u> - Day <u>18</u> Year <u>1961</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-05</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Erie, Penna</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Frank Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Butzer</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)							
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Hosp Records</u>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X</u> DUE TO <u>Meningitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of pancreas (head)</u> DUE TO <u> </u> (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 13, 1961</u> to <u>May 18, 1961</u> that (I) (we) last saw the deceased alive on <u>May 18, 1961</u> and that death occurred at <u>8:25 P.</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>Raymond O. West</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>				22d. ADDRESS <u>7600 Carroll Ave. Takoma Park, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 24, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Home Cemetery</u>				23d. LOCATION (City, town or county) <u>Youngstown, Ohio.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll Rd NW DC</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>					
DATE <u>MAY 22 '61</u>															

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1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5727

05715

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dawsonville</u> c. LENGTH OF STAY IN 1b <u>9 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ind R-121 - Boyle</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dawsonville</u> X d. STREET ADDRESS <u>Ind R-121 Boyle</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Harvey Appleman</u>			4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1961</u>		
5. SEX <u>male</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9-28-'71</u>		
9. AGE (In years last birthday) <u>89</u> yrs.			10. IF UNDER 1 YEAR Months <u>26</u> Days <u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Board Employee</u>			11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Loa Appleman</u>		
14. MOTHER'S MAIDEN NAME <u>Rose Daniel -</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>9776X</u>			17. INFORMANT <u>Margaret Peters</u> Address <u>133 Aldrich Rd. Columbus Ohio</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central hemorrhage + laceration</u> DUE TO (b) <u>bullet wound in skull</u> DUE TO (c) <u>sudden</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Self-inflicted bullet wound in skull</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound in skull</u>		
20c. TIME OF INJURY Month, Day, Year <u>8:45 a.m. 5-26-1961</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			20f. (City or town) <u>Dawsonville</u> (County) <u>Montg</u> (State) <u>md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>5-26-61</u>		
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 29-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>River Forest -</u>	
22d. LOCATION (City, town, or country) <u>South Bend Indiana</u>		(State) <u>Ind</u>			
23. FUNERAL DIRECTOR <u>Willie C. Helton, Barnesville, Md</u>			24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		
24b. REGISTRAR'S SIGNATURE			DATE <u>MAY 31 '61</u>		

TO THE COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

28

DATE _____

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[Faint, illegible handwriting covering the majority of the page, possibly bleed-through from the reverse side.]

1
FOR STATE
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 10-21, Film G-287 5/15/61.cac.											
1. PLACE OF DEATH e. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montg.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San & Hospital						d. STREET ADDRESS 7335 Carroll Ave					
3. NAME OF DECEASED (Type or print) First Robin Middle Louise Last Atchley						4. DATE OF DEATH Month May Day 1 Year 1961					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/14/60		9. AGE (in years last birthday) 1		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Euel Atchey						14. MOTHER'S MAIDEN NAME Esther Nixon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Euel Atchey				Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Miltown poisoning 871.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Blood contained 20 mg.% Meprobamate (c) Liver contained 18mg. % Meprobamate. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days	
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Took Miltown tabs. at home.							
20c. TIME OF INJURY Month, Day, Year 8-9 p.m. 4-29- 19 61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Takoma Park, Montgomery, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 5/2/61										Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1961		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or country) Prince Georges County, Md.		(State)			
23. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll St NW. D.C.						24a. REC'D BY REGISTRAR MAY 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, pay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5730

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G288 6/12/61 mh

05719

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ilkey</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>monty Gen. Hosp</u>		d. STREET ADDRESS <u>7201 Riverdale Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Helena Wellinia Baier</u>		4. DATE OF DEATH <u>May 30 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-5-1881</u>
9. AGE (In years, last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>	
11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C</u>	
13. FATHER'S NAME <u>Gen. Baier</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dilger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Flouise Gude (niece) Stum 2</u>	
17. INFORMANT <u>Flouise Gude (niece) Stum 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Coronary Thrombosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Boschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BOSCHERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-31-61</u>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Alexandria Virginia</u>	
23. FUNERAL DIRECTOR <u>P. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 2 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Dech's

Dech's Company, Inc.

Dech's Company, Inc.

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5731
CERTIFICATE OF DEATH

05720

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 4535 Taney Ave. - Apt. 203 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Anthony Edward BAKER		4. DATE OF DEATH Month May Day 15 Year 1961		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1961		9. AGE (In years last birthday) yrs. 16 Months 23 Days 16 Hours 23 Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Edwin BAKER				14. MOTHER'S MAIDEN NAME Lea Marie FERRARI				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT (F) George E. Baker, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that he (this hospital) attended the deceased from May 14, 1961 to May 15, 1961 , that (X) (we) last saw the deceased alive on May 15, 1961 , and that death occurred at 7:30AM , from the causes and on the date stated above.												INTERVAL BETWEEN ONSET AND DEATH 16 hrs 23 min							
22a. SIGNATURE Lawrence G. Thorne 22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN				22b. DATE SIGNED 5-15-61				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22e. REC'D BY REGISTRAR MAY 18 '61				22f. REGISTRAR'S SIGNATURE Arthur S. Kraus			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				23b. DATE THEREOF 5-16-61				23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION (City, town or county) (State) Norfolk Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Jr.				24. ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR MAY 18 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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Memorandum for the Director, Bureau of Prisons, Washington, D.C.

Subject: (Name)

1 day

Alexander

Virginia

U. S. Naval Hospital

4535 Tenth Ave. - Apt. 203

Agency

x

May 10, 1961

19

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Virginia

USA

George Edwin Barker

San Mateo, California

Re: (2) George E. Barker, name as above

Handwritten signature

May 10

May 10

May 10

May 10

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May 10

Lawrence G. Smith, Jr., MD, USN, U. S. Naval Hospital, Bethesda, Md.

Bureau of Prisons, Washington, D.C.

R. A. Humphrey, Federal Home, Bethesda, Md.

Norfolk

Virginia

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05721

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12620 Colston Rd</u>	
c. LENGTH OF STAY IN 1b <u>2 hrs</u>		d. STREET ADDRESS <u>12620 Colston Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>meth. Church - E. W. City & York Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Harvey Baker</u>		4. DATE OF DEATH <u>May 26 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. AGE (In years last birthday) <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>meth.</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey Baker</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-8722</u>	
17. INFORMANT <u>Eliz. Baker (wife)</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4201</u> DUE TO <u>Cornary occlusion</u> (c) <u>4201</u> DUE TO <u>Cornary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous Cornary disease</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschany</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSHANY</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 29, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Towson, Maryland</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>		DATE <u>JUN 1 '61</u>	



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

5733

05722

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Katherine Middle Beatrice Last Bateman				4. DATE OF DEATH Month May Day 14 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1918	
9. AGE (In years lost birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold W. Ireland				14. MOTHER'S MAIDEN NAME Olive B. Hambley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 146-32-2351			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 hours 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 11, 1961 to May 14, 1961 , that (I) (we) lost saw the deceased alive on May 14, 1961 , and that death occurred at 4:12 PM from the causes and on the date stated above.							
22a. SIGNATURE Thomas E. Gaffney				22b. DATE SIGNED 5/15/61			
22c. PHYSICIAN'S NAME (Type) THOMAS E. GAFFNEY, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/16/61		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Toronto, Canada	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				25a. REC'D BY REGISTRAR DATE MAY 17 '61		25b. REGISTRAR'S SIGNATURE Arthur J. Thomas	

FOR REVIEW

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if necessary, by a physician, or by a coroner, or by a funeral director, or by a person designated by the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>42 Kensington</u>	
c. LENGTH OF STAY in 1b <u>4 yr</u>		d. STREET ADDRESS <u>13515 Plym's mill ct</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3515 Plym's mill ct</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry</u>		4. DATE OF DEATH <u>May 22 1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-7-1913</u>	
9. AGE (in years last birthday) <u>47</u>		10. IF UNDER 1 YEAR Months <u>22</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carlo Bauer</u> <u>Germany</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Tatusik</u> <u>Poland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>225-05-0294</u>	
17. INFORMANT <u>Wivian Bauer (wife)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Fund dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous Cornary disease</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bluschatz</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bluschatz</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 25, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 29 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
INVESTIGATION OF THE DEATH OF

1934

1934

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14

1934-11-20

1934

RECEIVED BY THE ATTORNEY GENERAL
ON 11-20-34
FILED IN 1934-11-20

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5735

Item 2 Md. 6287 5/22/61 mh

05724

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL — SILVER SPRING		c. LENGTH OF STAY IN 1b 5 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SEYMOUR NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TERESA Middle V Last BAZZURO		4. DATE OF DEATH Month MAY Day 13 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-1881
9. AGE (In years lost birthday) 80 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) WASH., D.C.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME BERNARD OSTMANN		14. MOTHER'S MAIDEN NAME MARY LOCHBOEHLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MARY REED Address 14708 CROSSWAY RD. ROCKVILLE 13, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC CARDIAC DECOMPENSATION DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAY 10 , 19 61 , to MAY 13 , 19 61 , that (I) (we) last saw the deceased alive on MAY 12 , 19 61 , and that death occurred at 5A M, from the causes and on the date stated above.			
22a. SIGNATURE Gene U. Cohen, M.D. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MAY 13, 1961	
22c. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.		22d. ADDRESS 931 PERSHING DR. SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/16/61	23c. NAME OF CEMETERY OR CREMATORY St. Mary's	23d. LOCATION (City, town, or county) (State) Washington 10 C.
24. FUNERAL DIRECTOR'S SIGNATURE Frank Desera Sons Co ADDRESS 3605-14 St NW Wash. 10 C.		25a. REC'D BY REGISTRAR MAY 15 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1953

STATE OF TEXAS

1953

(M)

NOTARY PUBLIC

I, the undersigned, Notary Public for the State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original of the same, as the same appears from the records of my office.

Witness my hand and the seal of my office this 1st day of January, 1953.

Notary Public for the State of Texas

My Comm. Expires Jan 1, 1954

My Office is at

City of

County of

State of Texas

Notary Public

VS. AISME
5M 7/59

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5736

05725

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>420 Deerfield Ave</u>		d. STREET ADDRESS <u>420 Deerfield Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Leah</u> Middle <u>Berman</u> Last <u>Berman</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-96</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Russian</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HILKEL Kramm</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Goldie Stoller</u>		Address <u>Strom</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u> </u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>History of previous coronary disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		DATE SIGNED <u>5-3-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THROF <u>5/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM</u>		22d. LOCATION (City, town, or country) (State) <u>FALLS CHURCH VA</u>	
23. FUNERAL DIRECTOR <u>Greater Funeral Home</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 5 '61</u>	
ADDRESS <u>4217-9th St NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

05560

MARYLAND DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3838

100-11111

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the signature of the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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074
MONTGOMERY
MAY 11 1961
5726

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>24 hrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> b. COUNTY <u>San Bernardino</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>San Bernardino</u> d. STREET ADDRESS <u>1126 W. Marshall Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>Marie</u> Last <u>Binney</u>		4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 17 1897</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Schoefer</u>		14. MOTHER'S MAIDEN NAME <u>Anna (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Frank H. Binney - husband</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>260X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atelectasis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-5</u> 19 <u>61</u> to <u>5-11</u> 19 <u>61</u> , that (I) <u>last</u> saw the deceased alive on <u>5-11</u> 19 <u>61</u> , and that death occurred at <u>1304</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James W. Egan</u>		22b. DATE SIGNED <u>May 11, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES W. EGAN</u>		22d. ADDRESS <u>7720 Wisconsin Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 5-11-61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>San Bernardino, Calif.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 15 '61</u>	
ADDRESS <u>Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5738

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05727

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>5 yrs</u>				d. STREET ADDRESS <u>19904 Sutherland Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9904 Sutherland Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lester S. Birely Jr.</u>		4. DATE OF DEATH <u>May 8</u> 19 <u>61</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Aug 27 1927</u>		9. AGE (in years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vitro Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Lester S. Birely</u>				14. MOTHER'S MAIDEN NAME <u>Elinor Beard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>212-24-7359</u>			
17. INFORMANT <u>Lester S. Birely</u>				Address <u>Thurmont, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>971.8</u> <u>Combined barbiturate and alcohol poisoning.</u>							
DUE TO (b) <u>Blood contained 1.6 mg. % barbiturate and 0.29 % alcohol.</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-10-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Thurmont, Maryland</u>			
23. FUNERAL DIRECTOR <u>Raymond E. Creager</u>				ADDRESS <u>Thurmont, Md.</u>			
24a. REC'D BY REGISTRAR <u>MAY 11 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			


MEDICAL CERTIFICATION

ST. JOHN'S COLLEGE, NEW YORK

2672



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5739

05728

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY Tallahassee c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tallahassee d. STREET ADDRESS RR 4, Box 226 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Douglas BLOWERS		4. DATE OF DEATH Month May Day 16 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-23-36
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months 25 Days 16 Hours 19 Min. 61	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		11b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William BLOWERS	
14. MOTHER'S MAIDEN NAME Margaret BAKER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1953 to DOD	
16. SOCIAL SECURITY NO. 219-32-5885		17. INFORMANT (W) Mrs. Barbara K. Blowers, same as item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse cerebritis and brain abscess DUE TO 343X Conditions, if any, which gave rise to immediate cause (b) unknown cause DUE TO 343X (c) unknown cause INTERVAL BETWEEN ONSET AND DEATH 3 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6 May 1961 to 16 May 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 16 May 1961 , and that death occurred at 12:01PM from the causes and on the date stated above.			
22a. SIGNATURE J. H. MILLER LT MG, USN		22b. DATE SIGNED 5-16-61	
22c. PHYSICIAN'S NAME (Type) J. H. MILLER LT MG, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 1400 Chapin St., NW, WashDC		25a. REC'D BY REGISTRAR MAY 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

(M)

Montgomery

Bethesda (Mental)

10 days

Tallahassee

Florida

U. S. Naval Hospital

HR 4, Box 320

William

Douglas

BLOWERS

MAY

10

01

Note

Cancellation

x

3-23-30

25

Officer

U. S. Navy

Maryland

USA

William BLOWERS

Maryland

(I)

100

1933 to 1935

SLR-32-2007 (W) Mrs. Barbara K. BLOWERS, same as item 1

100

X

x

10 May

01

6 May

12:01 PM

10 May

01

10

9-10-01

x

U. S. Naval Hospital, Bethesda, Md.

U. S. Naval Hospital, Bethesda, Md.

Bethesda

9-10-01

Baltimore National City

Baltimore

Md.

U. S. Naval Hospital, Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5740

CERTIFICATE OF DEATH

Reg. Dist. No. 5729

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's		c. LENGTH OF STAY IN lb 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Buck Lodge Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle H. Last Bolton		4. DATE OF DEATH Month May Day 9 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Montgomery Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Bolton	
14. MOTHER'S MAIDEN NAME Sarah Anne Bolton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-16-7979		INFORMANT Address Raymond E. Justice, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 12 hours 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 24 Dec , 19 60 , to 9 May , 19 61 , that I last saw the deceased alive on 9 May , 19 61 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE John W. Smith M.D. Barnesville, Md DATE SIGNED 9 May 61 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 12, 1961	22c. NAME OF CEMETERY OR CREMATORY Rockville	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth		24a. REC'D BY REGISTRAR DATE MAY 15 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

CERTIFICATE OF DEATH

755

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

REMARKS

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

DATE OF SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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M
5741
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

65730

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 29 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4117 Beck Street, S. E. d. STREET ADDRESS 4117 Beck Street, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Beulah Marie BOSWORTH		4. DATE OF DEATH Month Day Year May 19 1961	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-81
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Notley HOWELL	
14. MOTHER'S MAIDEN NAME Mabel (Unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	
16. SOCIAL SECURITY NO. None		17. INFORMANT (H) Dudley C. Bosworth, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, n.e.c. primary unknown DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (his hospital) attended the deceased from April 20 1961 to May 19 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 19 1961 , and that death occurred at 2:40AM , from the causes and on the date stated above.			
22a. SIGNATURE James M. Young M.D.		22b. DATE SIGNED 5-19-61	
22c. PHYSICIAN'S NAME (Type) James M. YOUNG, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/61	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass. Aves., NW, WashDC		25a. REC'D BY REGISTRAR DATE MAY 23 '61	
25b. REGISTRAR'S SIGNATURE James S. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05731

FOR STATE
HEALTH DEPT

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>35 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Edson Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1 Edson Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Graft Bowie</u> First Middle Last				4. DATE OF DEATH <u>May 23 1961</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-7-1893</u> last birthday	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Ta</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John J. Graft</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Ray</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mary Ellen Brewer</u> Address <u>Newman - 4055 La Rockville, md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c) <u>420.1</u> DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>							
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BIOSCHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE <u>5-23-61</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAY 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

100



None

Robert A. Pughrey, Bethesda, Maryland
John T. Pughrey, Rock Creek Cemetery, Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5743

05732

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 813 Gist Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) THOMAS MARSHALL BRADY		4. DATE OF DEATH May 1 1961		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-92		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? US.							
13. FATHER'S NAME George A. Brady				14. MOTHER'S MAIDEN NAME Sarah Thomas				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) Yes WWI				16. SOCIAL SECURITY NO. 579-12-8579				17. INFORMANT Daughter Mary Anne Brady Sinclair Address 813 Gist Ave Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, myocardium 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (a) (this hospital) attended the deceased from 28 April 1961 , to 1 May 1961 , that (b) (we) last saw the deceased alive on 1 May 1961 , and that death occurred at 6:04 PM from the causes and on the date stated above.																			
22a. SIGNATURE Russell Miller, Jr. MD M.D.				22b. DATE SIGNED 1 May 1961				22c. PHYSICIAN'S NAME (Type) RUSSELL MILLER, JR. LT MC USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-4-61				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Arlington Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE Norman J. Grabe for W.E. PUMPHREY FUNERAL HOME, SILVER SPRING MD				25a. REC'D BY REGISTRAR DATE MAY 4 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kline											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



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CERTIFICATE OF DEATH

Reg. Dist. No. 05733

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3218 E. Thornapple Street				d. STREET ADDRESS 3218 E. Thornapple Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Harry Middle A Last Bright				4. DATE OF DEATH Month May Day 22 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1891	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 3 Days 17		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist				10b. KIND OF BUSINESS OR INDUSTRY Chemistry		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Layman Bright				14. MOTHER'S MAIDEN NAME Emma Madora			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Lynne A. Bright-wife-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 754-5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure (c) Valvular heart disease				INTERVAL BETWEEN ONSET AND DEATH 15-30 min 9 months congenital			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec 50 , 19 50 , to 22 May , 19 61 , that I last saw the deceased alive on 15 May , 19 61 , and that death occurred at 11:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5029 BETHESDA AVE DATE SIGNED 22 May 61							
ACTUAL SIGNATURE Herbert Martyn Jr				PHYSICIAN'S NAME (Type) HERBERT MARTYN JR Bethesda Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/61		22c. NAME OF CEMETERY OR CREMATORY Charles Evans Cem.		22d. LOCATION (City, town, or county) (State) Reading, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 25 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John J. Jones	
Sex		Male	
Age		35	
Date of Birth		1915	
Place of Birth		Maryland	
Usual Residence		2518 E. Thompson Street	
Cause of Death		Myocardial Infarction	
Date of Death		1950	
Place of Death		Home	
Physician		Dr. J. H. Smith	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05734

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>1000 Laytonville P.O.</u>	
3. NAME OF DECEASED (Type or print) <u>Wilbur Eugene Bright, Jr.</u>		4. DATE OF DEATH <u>MAY 21 19 61</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/61</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>	
11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>15</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILBUR EUGENE BRIGHT</u>		14. MOTHER'S MAIDEN NAME <u>SHIRLEY LYLES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>—</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Placenta previa</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO (c) <u>Twin Pregnancy</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>61</u> , to <u>5/21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5/26</u> , 19 <u>61</u> , and that death occurred at <u>9:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Francis Lawrence</u> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Browne</u> ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR <u>29</u> DATE <u>5/29/61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>			

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15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05735

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baithsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1000 Keytonville P.O.</u>	
3. NAME OF DECEASED (Type or print) <u>Wilma</u> First <u>MARRIE</u> Middle <u>MARRIE</u> Last <u>BRIGHT</u>		4. DATE OF DEATH <u>May</u> <u>21</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21, 1961</u>
9. AGE (In years last birthday) <u>10</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILBUR EUGENIE BRIGHT</u>		14. MOTHER'S MAIDEN NAME <u>SHIRLEY — ZYLES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atalectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic</u> (c) <u>Jejun Prognosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>61</u> , to <u>5/21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert L. Brandon</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Brandon</u> ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 29 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX MALE	
3. AGE 65		4. DATE OF DEATH JAN 10 1900	
5. PLACE OF DEATH HOME		6. TIME OF DEATH 10:00 AM	
7. CAUSE OF DEATH HEART DISEASE		8. DISEASE OR INJURY HEART DISEASE	
9. OCCASION OF DEATH WINTER		10. PLACE OF BIRTH BALTIMORE	
11. NAME OF PHYSICIAN J. H. HARRIS		12. NAME OF BURIAL PLACE CATHOLIC CHURCH	
13. NAME OF FUNERAL HOME J. H. HARRIS		14. NAME OF MINISTER J. H. HARRIS	
15. NAME OF CLERGYMAN J. H. HARRIS		16. NAME OF WITNESSES J. H. HARRIS	
17. NAME OF CORONER J. H. HARRIS		18. NAME OF JURY J. H. HARRIS	
19. NAME OF JURY J. H. HARRIS		20. NAME OF JURY J. H. HARRIS	
21. NAME OF JURY J. H. HARRIS		22. NAME OF JURY J. H. HARRIS	
23. NAME OF JURY J. H. HARRIS		24. NAME OF JURY J. H. HARRIS	
25. NAME OF JURY J. H. HARRIS		26. NAME OF JURY J. H. HARRIS	
27. NAME OF JURY J. H. HARRIS		28. NAME OF JURY J. H. HARRIS	
29. NAME OF JURY J. H. HARRIS		30. NAME OF JURY J. H. HARRIS	
31. NAME OF JURY J. H. HARRIS		32. NAME OF JURY J. H. HARRIS	
33. NAME OF JURY J. H. HARRIS		34. NAME OF JURY J. H. HARRIS	
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37. NAME OF JURY J. H. HARRIS		38. NAME OF JURY J. H. HARRIS	
39. NAME OF JURY J. H. HARRIS		40. NAME OF JURY J. H. HARRIS	
41. NAME OF JURY J. H. HARRIS		42. NAME OF JURY J. H. HARRIS	
43. NAME OF JURY J. H. HARRIS		44. NAME OF JURY J. H. HARRIS	
45. NAME OF JURY J. H. HARRIS		46. NAME OF JURY J. H. HARRIS	
47. NAME OF JURY J. H. HARRIS		48. NAME OF JURY J. H. HARRIS	
49. NAME OF JURY J. H. HARRIS		50. NAME OF JURY J. H. HARRIS	
51. NAME OF JURY J. H. HARRIS		52. NAME OF JURY J. H. HARRIS	
53. NAME OF JURY J. H. HARRIS		54. NAME OF JURY J. H. HARRIS	
55. NAME OF JURY J. H. HARRIS		56. NAME OF JURY J. H. HARRIS	
57. NAME OF JURY J. H. HARRIS		58. NAME OF JURY J. H. HARRIS	
59. NAME OF JURY J. H. HARRIS		60. NAME OF JURY J. H. HARRIS	
61. NAME OF JURY J. H. HARRIS		62. NAME OF JURY J. H. HARRIS	
63. NAME OF JURY J. H. HARRIS		64. NAME OF JURY J. H. HARRIS	
65. NAME OF JURY J. H. HARRIS		66. NAME OF JURY J. H. HARRIS	
67. NAME OF JURY J. H. HARRIS		68. NAME OF JURY J. H. HARRIS	
69. NAME OF JURY J. H. HARRIS		70. NAME OF JURY J. H. HARRIS	
71. NAME OF JURY J. H. HARRIS		72. NAME OF JURY J. H. HARRIS	
73. NAME OF JURY J. H. HARRIS		74. NAME OF JURY J. H. HARRIS	
75. NAME OF JURY J. H. HARRIS		76. NAME OF JURY J. H. HARRIS	
77. NAME OF JURY J. H. HARRIS		78. NAME OF JURY J. H. HARRIS	
79. NAME OF JURY J. H. HARRIS		80. NAME OF JURY J. H. HARRIS	
81. NAME OF JURY J. H. HARRIS		82. NAME OF JURY J. H. HARRIS	
83. NAME OF JURY J. H. HARRIS		84. NAME OF JURY J. H. HARRIS	
85. NAME OF JURY J. H. HARRIS		86. NAME OF JURY J. H. HARRIS	
87. NAME OF JURY J. H. HARRIS		88. NAME OF JURY J. H. HARRIS	
89. NAME OF JURY J. H. HARRIS		90. NAME OF JURY J. H. HARRIS	
91. NAME OF JURY J. H. HARRIS		92. NAME OF JURY J. H. HARRIS	
93. NAME OF JURY J. H. HARRIS		94. NAME OF JURY J. H. HARRIS	
95. NAME OF JURY J. H. HARRIS		96. NAME OF JURY J. H. HARRIS	
97. NAME OF JURY J. H. HARRIS		98. NAME OF JURY J. H. HARRIS	
99. NAME OF JURY J. H. HARRIS		100. NAME OF JURY J. H. HARRIS	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5747

05736

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>47X</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Paloma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
c. LENGTH OF STAY in 1b <u>4 days</u>				d. STREET ADDRESS <u>1400 Holly Street NW</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. & Hosp</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Susie (B) Broadhurst</u>				4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-25-98</u> yrs. <u>63</u>	
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>			
13. FATHER'S NAME <u>John Lindsay, Va.</u>				14. MOTHER'S MAIDEN NAME <u>Susie Boswell, Md.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Hospital record</u>				Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Posterior Myocardial Infarction</u>							
DUE TO (b) <u>Coronary occlusion</u>							
DUE TO (c) <u>arteriosclerotic Heart Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 19 57</u> to <u>May 10, 1961</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>May 10, 1961</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Russell B. Arnold</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>				22d. ADDRESS <u>8801 Colesville Road, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/13/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's Co. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				25. REC'D BY REGISTRAR <u>MAY 16 '61</u>			
ADDRESS <u>8434 Georgia Ave, Silver Spring, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5748

05737

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville c. LENGTH OF STAY IN 1b 71 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hatton Darby Brown				4. DATE OF DEATH Month Day Year May 26 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 2-1890	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-----Owner--Active				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Clifton Brown				14. MOTHER'S MAIDEN NAME Mary Darby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 270-07-7642		17. INFORMANT Richard Brown, Barnesville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) coronary arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 5 min. 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 22 April, 1961 to 26 May, 1961 , that (I) (we) last saw the deceased alive on 23 May 1961 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Gordon M. Smith				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 27 May 61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Gordon M. Smith				22d. ADDRESS Barnesville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29-1961		23c. NAME OF CEMETERY OR CREMATORY Monocacy		23d. LOCATION (City, town or county) (State) Beallsville, Md	
24 FUNERAL DIRECTOR'S SIGNATURE William B. Hillen				25a. REC'D BY REGISTRAR MAY 31 61		25b. REGISTRAR'S SIGNATURE Robert S. Hillen	

M

3728

Montgomery

Harrodsburg

71 yrs

Harrodsburg

Montgomery

Montgomery

Union

Barby

Brown

May 28

61

Male

White

Jan 2-1890

71

Former--Owner--Active

Montgomery

U.S.

Elison Brown

Barby

270-07-7042 Richard Brown, Harrodsburg, Ind

NO

D. Bailey, Harrodsburg

Gordon H. Smith

Harrodsburg, Ind

Barby May 28-1901 Montgomery

Harrodsburg, Ind

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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5749
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05738

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN TB <u>life</u>				d. STREET ADDRESS <u>8009 Maple Ridge Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8009 Maple Ridge Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Harry Buchm</u>				4. DATE OF DEATH <u>May 29 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-3-1918</u>	
9. AGE (in years last birthday) <u>42</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Graef W. Buchm</u>				14. MOTHER'S MAIDEN NAME <u>Vera Mangen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Vera Buchm (mother)</u>				Address <u>Stue 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor (inoperable)</u> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bluschek</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLUSCHKE</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>5-31-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>				22d. LOCATION (City, town, or country) (State) <u>PRINCE GEORGES COUNTY, MD.</u>			
23. FUNERAL DIRECTOR <u>Francis Hollins</u>				ADDRESS <u>3821-14th St. N.W. Wash. D.C.</u>			
24a. REC'D BY REGISTRAR <u></u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician, and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, not later than 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5750

Item 2 Film G287

5/24/61

05739

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 48 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Bethesda 14 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium STREET ADDRESS 4857 Battery Lane 3300 McComas Ave., Kensington, Md.	
3. NAME OF DECEASED (Type or print) Ada Kirk		4. DATE OF DEATH Month May Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 3 Days 3 IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Josiah Kirk		14. MOTHER'S MAIDEN NAME Anne Reynolds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. ADDRESS Mrs. Donald Dudley, 4857 Battery La., Beth. Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1961 to May 12, 1961 , that (I) (we) last saw the deceased alive on May 12, 1961 , and that death occurred at 7:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph Kenrick		22b. DATE May 13, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph Kenrick		22d. ADDRESS 6450 Wisconsin Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 5-15-61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Brook View Cemetery		23d. LOCATION (City, town or county) (State) Rising Sun, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR MAY 18 61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05740

5751

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. LENGTH OF STAY IN 1b 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 26720 Ridge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lolita Middle Young Last Burdette		4. DATE OF DEATH Month May Day 9 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1880
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 00 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Damascus, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Dallas Young		14. MOTHER'S MAIDEN NAME Caroline Etchison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs James Kent Day		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, acute, recurrent 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerosis, generalized DUE TO (c) 20 years		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; cerebro-vascular accidents, multiple			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15 , 19 55 , to May 9 , 19 61 , that I last saw the deceased alive on May 9 , 19 61 , and that death occurred at 12:53 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) Main Street	
PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D.		Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11, 1961	
22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE MAY 12 '61		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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(M)

(1)

Female

White

Age 22, 1989

Van Horn

Houma, La.

James Dallas Young

Caroline Young

774 James Road, Bay, St. Bernard, La.

Darlington, Md.

Darlington, Md.

May 11, 1981

Female

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5752

05741

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 615 W. Lynfield Drive				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 615 W. Lynfield Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JUNE E BURTON		4. DATE OF DEATH Month May Day 27 Year 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6/2/1925 9. AGE (In years last birthday) 35 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 13. FATHER'S NAME John S. Grillo		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? USA		14. MOTHER'S MAIDEN NAME Olympia Pascal			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) 16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Richard Burton-Husband-same 2d Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC AND PULMONARY METASTASES DUE TO (b) CARCINOMA OF BREAST Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 170X				INTERVAL BETWEEN ONSET AND DEATH 6 MOS 28 MOS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from AUGUST, 1960 to MAY 27, 1961 , that (I) (we) last saw the deceased alive on MAY 27, 1961 , and that death occurred at 9:15A , from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i> 22c. PHYSICIAN'S NAME (Type) JOHN H. TUOHY, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 7720 WISCONSIN AVE BETHESDA, MD.		22b. DATE SIGNED 5/27/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAY 31 '61			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

(1)

5758

North Carolina
Rockville

625 N. Lumbard Drive

June

Female White

Longhair
John A. Griffin

Unknown

Richard Burton-Robertson-20

CHURCH AND UNIVERSITY MEMBERS
CHURCH OF THE BREAST

Five

May 27, 1961

John H. Tamm, Jr.

Robert A. Humphrey Bethesda, Maryland
Arlington Hall, Va. Arlington, Virginia

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5753

05742

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8018 Park Lane				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8018 Park Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle R. Last CANADA				4. DATE OF DEATH Month May Day 12 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1897	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME George Donaldson		14. MOTHER'S MAIDEN NAME Margaret Hickey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Failure. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) MYO CARDIAL INFARCT (c) ARTEROSCLEROTIC heart disease.		INTERVAL BETWEEN ONSET AND DEATH -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1960 to Present , that (1) last saw the deceased alive on May 9 1961 , and that death occurred at 6:00 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Donald F. Ekman				22b. DATE SIGNED 5/12/61		22c. PHYSICIAN'S NAME (Type) DONALD Q. EKMAN	
22d. ADDRESS 5707 Wisconsin Ave, Chevy Chase, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-15-61		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR MAY 18 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

Montgomery

Maryland

Bethesda

Bethesda

5018 Park Lane

5018 Park Lane

ELIZABETH

CANADA

NEW

01

Female White

Jan. 20, 1907

Housewife

Washington, D. C.

George Washington

Married Money

5030 Greenview Rd.

Washington

Mr. E. A. Pappalardo

Home

Home

I

CARE OF

440 Madison Ave.

George Washington University

Oct

FRANK Q. ARMAN

3707 Wisconsin Ave, Chevy Chase, Md.

Burial

5-15-01

Gate of Heaven

Silver Spring, Maryland

ROBERT A. BURNHAY

Bethesda, Md.

11-1-01

11-1-01

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

5754

05743

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>			
c. LENGTH OF STAY IN 1b <u>24 yrs</u>				d. STREET ADDRESS <u>4419 Strathmore Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4419 Strathmore Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Leslie Maynard Cannon</u>		4. DATE OF DEATH <u>May 26 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-91</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(Unknown) King</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-01-3233</u>		17. INFORMANT <u>Guilford Cannon (husband)</u>		Address <u>Stm 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>History of previous coronary disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>5-26-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Hyattsville, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>MAY 31 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

270-1-1223

Robert A. Humphrey, Bethesda, Maryland
George Mann, Cemetery, Haverhill, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 156 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 1420 Saratoga Avenue, N.E.	
3. NAME OF DECEASED (Type or print) First Paul Middle Arthur Last Carson		4. DATE OF DEATH Month May Day 24 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 3, 1904
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 24 Days 24 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Carson		14. MOTHER'S MAIDEN NAME Carrie Gregg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-07-9202	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion 141.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma DUE TO (c) Epidermoid carcinoma of tongue		INTERVAL BETWEEN ONSET AND DEATH 24 hours 3 weeks 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from December 19, 1960 to May 24, 1961 , that he (we) lost saw the deceased alive on May 24, 1961 , and that death occurred at 9:55 p.m. from the causes and on the date stated above.			
22a. SIGNATURE David J. Crawford M.D.		22b. DATE SIGNED 5/25/61	
22c. PHYSICIAN'S NAME (Type) DAVID T. CRAWFORD, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) burial		23b. DATE THEREOF 5/27/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,		25a. REC'D BY REGISTRAR MAY 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1

21 hours
3 weeks
10 months

21 hours
3 weeks
10 months

David C. [illegible]
[illegible]

TO DEPARTMENT OF HEALTH
MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05745

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1341-E. Capitol St. S.E.	
3. NAME OF DECEASED (Type or print) Herman Joseph Carter		4. DATE OF DEATH May 19 1961	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1915
9. AGE (In years last birthday) 45 yrs.		10. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Awning Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Burton Awning Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leighton Carter		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War 2		16. SOCIAL SECURITY NO. 577-05-2102	
17. INFORMANT Marjorie Carter		Address 11-35 th. St. S.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from ladder 24 ft while placing awnings	
20c. TIME OF INJURY Month, Day, Year 2:34 p.m. 5-19 1961		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Building		20f. (City or town) (County) (State) Cherry Chase Monty Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-23-61	
22c. NAME OF CEMETERY OR CREMATORY Arlington Mt. Va		22d. LOCATION (City, town, or country) (State) Long by new. Va	
23. FUNERAL DIRECTOR Robert A Mattingly		ADDRESS 131-11 St SE	
24a. REC'D BY REGISTRAR MAY 22 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

... [unclear] ...

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11. 10. 1911, 10. 11. 1911

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

$$r = 0.5, \quad \tau = 0.5, \quad \sigma = 0.5$$

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5757

05746

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 13 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS (SUNSHINE)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MONTGOMERY Middle WRIGHT Last CASHELL				4. DATE OF DEATH Month MAY Day 19 Year 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-15-1876		9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE WASHINGTON CASHELL				14. MOTHER'S MAIDEN NAME CATHERINE AUGUSTA HOBBS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis. INTERVAL BETWEEN ONSET AND DEATH 2 wks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/5/61 19 61 , to 5/19 19 61 , that (I) (we) last saw the deceased alive on 5/19 19 61 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Richard A. Yates				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/19/61	
22c. PHYSICIAN'S NAME (Type) R. A. YATES, M. D.				22d. ADDRESS OLNEY, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-22-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION (City, town, or county) (State) Sunshine, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 25 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

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CERTIFICATE OF DEATH



DECEASED

DATE

TIME

PLACE

CAUSE

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

DIAGNOSIS

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

TESTAMENTS

TESTAMENTS

TESTAMENTS

TESTAMENTS

TESTAMENTS

5758

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05747

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 1 Hr.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 25		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4939 Cordell Ave.			d. STREET ADDRESS 929 GIST AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ferdinand P Cayelli			4. DATE OF DEATH Month MAY Day 11 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1905		9. AGE (in years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY A.B. Engineering Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania, Mason Town	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Daniel Cayelli Italy			14. MOTHER'S MAIDEN NAME Eletta Archangeli Italy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-6779		17. INFORMANT 929 Gist Avenue Mrs. Nell R. Cayellie Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, sudden 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous Heart Disease					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Silver Spring	(County) Montgomery	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/11/61	
EXAMINER'S NAME (Type) Dr. Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 15, 1961	22c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven, Cemetery Montgomery Co. Maryland		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE MAY 17 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10. The following table shows the number of people who attended the 2001 World Cup in football (soccer) in each of the 12 host cities. The number of people who attended the matches in each city is given in thousands.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5755

05748

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN 1b Washington Sanitarium and Hosp. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, d. STREET ADDRESS 8504 16th Street, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Male First Chaikin Middle Chaikin Last Chaikin		4. DATE OF DEATH Month May Day 26, Year 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1961	
9. AGE (In years, last birthday) yrs. 19 Months 0 Days 0 Hours 0 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME George - Chaikin		14. MOTHER'S MAIDEN NAME L. Judith Shapiro	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT father		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural & subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 758.1 (c) Achondroplastic dwarfism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from May 25, 1961, to May 26, 1961, that (I) (we) last saw the deceased alive on May 25, 1961, and that death occurred at 2:30 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Sydney Leventhal M.D.		22b. DATE SIGNED May 26, 1961	
22c. PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.		22d. ADDRESS 9210 Coleridge Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6-3-61	
23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D. Washington San. & Hospital		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE CONFIDENTIAL	

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Robert A. Lee, M.D., Sananton 3m. & Hospital

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CERTIFICATE OF DEATH

Reg. Dist. No.

05749

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mollie Middle Marvella Last Childs		4. DATE OF DEATH Month May Day 3 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1881
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aden Allnutt		14. MOTHER'S MAIDEN NAME Martha Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. William Childs		Address Derwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Brain (c) Chronic Pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH 6 hrs Yes Yes.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to 5/3 , 19 61 , that I last saw the deceased alive on 4/29 19 61 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE C. H. Ligon, M.D.		M.D.	
PHYSICIAN'S NAME (Type) C. H. Ligon, M.D.		Medical Center, Sandy Spring, Md. 5/3/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-5-61	22c. NAME OF CEMETERY OR CREMATORY St. John	22d. LOCATION (City, town, or county) (State) Olney, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Frankie H. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR DATE MAY 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5761

CERTIFICATE OF DEATH

06896

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park,</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u> d. STREET ADDRESS <u>Box 6,</u>			
3. NAME OF DECEASED (Type or print) <u>L.C.</u> - <u>Christian Jr.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>28,</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 28, 1961</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>L.C. - Christian</u>				14. MOTHER'S MAIDEN NAME <u>Peggy Ann Meade</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>father</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis and emphysema</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Microscopic pulmonary pathology suspected</u> DUE TO (c) <u>(Microscopies to follow.)</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald Straus</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-28-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald Straus, M. D.</u>				22d. ADDRESS <u>3400 May St., Silver Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5-29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Wash. San. & Hospital</u>				25a. REC'D BY REGISTRAR <u>JUN 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

068861

1961

(M)

Washington Center on the Hospital
 Box 6
 Christian St.
 May 28, 1961
 Mr. and Mrs. [Name]
 1000 [Address]
 Washington, D.C.
 Dear Sirs:

(I)

Following is a list of the
 microscopic pathology material
 (also known as follow-up)

Donald Brown

Donald Brown, M.D.
 3500 and St., Silver Spring, Maryland
 Washington Center on the Hospital, Landon Park, Md.
 Robert A. Hays, M.D., Wash. San. & Hospital

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5762

057511

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> d. STREET ADDRESS <u>1709 Lebanon St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Michael Alexander Codirezzi</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-15</u>		9. AGE (In years last birthday) <u>45</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months	Days																		
Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Highway Dept</u>				11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Codirezzi</u>				14. MOTHER'S MAIDEN NAME <u>Grace Murgia</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>unk.</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compression BRAIN stem</u> DUE TO (b) <u>Cerebral oedema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Suprasellar neoplasm estimated 4 mos. +</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Suspected infarction left frontal lobe</u>												INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>approx 14 days</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>61</u> to <u>5/6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/5</u> , 19 <u>61</u> , and that death occurred on <u>5/6</u> , 19 <u>61</u> , at <u>4:12</u> P.M., from the causes and on the date stated above.																			
22a. SIGNATURE <u>John T. Lord M.D.</u>								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/6/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord</u>								22d. ADDRESS <u>1015 Spring Street Silver Spring Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MAY 9, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>				23d. LOCATION (City, town or county) (State) <u>Wheaton MD</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Cartmel</u>								ADDRESS <u>3603 14th St NW</u>		25a. REC'D BY REGISTRAR <u>MAY 8 '61</u>				25b. REGISTRAR'S SIGNATURE <u>John L. Hines</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "General", "information", and "date" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film G290 7/14/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 05751

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 1b 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHEATON NURSING HOME		d. STREET ADDRESS 2800 QUEBEC STREET, N.W.	
3. NAME OF DECEASED (Type or print) First COL. SAMUEL Middle FRANCIS Last COHN		4. DATE OF DEATH Month MAY Day 25 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1894
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Colonel		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	
11. BIRTHPLACE (State or foreign country) NEBRASKA Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS COHN		14. MOTHER'S MAIDEN NAME BLUMA ---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1917-1953	
17. INFORMANT MRS. FLORENCE COHN		Address -2800 QUEBEC ST., N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 280X Congestive Heart Failure DUE TO (b) Parkinson's Disease DUE TO (c) Diabetes Carcinoma of prostate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 years		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/23, 1961 to 5/25, 1961 , that I last saw the deceased alive on 5/25, 1961 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome J. Krick		ADDRESS (Street, city or town, state) 2800 QUEBEC STREET, N.W.	
PHYSICIAN'S NAME (Type) JEROME J. KRICK, M.D.		DATE SIGNED WASHINGTON, 8, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-29-61	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS		ADDRESS -3501 14th St., NW	
24a. REC'D BY REGISTRAR MAY 31 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

Page 4 after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and keep papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1904

1904

1904

1904

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1904

1
FOR STATE
HEALTH DEPT.

TO DEPENDENT: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

5764
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05752

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b DOH d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4431 35th Street, N. W. d. STREET ADDRESS 4431 35th Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Earl Walter COOK				4. DATE OF DEATH Month Day Year May 29 19 61			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-29-88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		9. AGE (In years last birthday) 73 yrs.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Vincent R. COOK				14. MOTHER'S MAIDEN NAME Mollie BROWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW1&11		17. INFORMANT (W()) Mrs. Mertie I. Cook, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. BROSCART, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-29-61		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-61		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington Virginia	
23. FUNERAL DIRECTOR W.W. Chambers Co.				24a. REC'D BY REGISTRAR JUN 1 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION

(L-100) 2000-01

Figure 1. Level 3.0.

1. *Chlorophyll a* (Chl *a*)

WILLIAM F. COOK

1151 20Y

55-9571

... ..

Discussion

(W) Mrs. Marie L. Goff, 2100 S. 2nd Ave.

1. $\frac{1}{2}$ 2. $\frac{1}{3}$ 3. $\frac{1}{4}$ 4. $\frac{1}{5}$ 5. $\frac{1}{6}$ 6. $\frac{1}{7}$ 7. $\frac{1}{8}$ 8. $\frac{1}{9}$ 9. $\frac{1}{10}$ 10. $\frac{1}{11}$ 11. $\frac{1}{12}$ 12. $\frac{1}{13}$ 13. $\frac{1}{14}$ 14. $\frac{1}{15}$ 15. $\frac{1}{16}$ 16. $\frac{1}{17}$ 17. $\frac{1}{18}$ 18. $\frac{1}{19}$ 19. $\frac{1}{20}$ 20. $\frac{1}{21}$ 21. $\frac{1}{22}$ 22. $\frac{1}{23}$ 23. $\frac{1}{24}$ 24. $\frac{1}{25}$ 25. $\frac{1}{26}$ 26. $\frac{1}{27}$ 27. $\frac{1}{28}$ 28. $\frac{1}{29}$ 29. $\frac{1}{30}$ 30. $\frac{1}{31}$ 31. $\frac{1}{32}$ 32. $\frac{1}{33}$ 33. $\frac{1}{34}$ 34. $\frac{1}{35}$ 35. $\frac{1}{36}$ 36. $\frac{1}{37}$ 37. $\frac{1}{38}$ 38. $\frac{1}{39}$ 39. $\frac{1}{40}$ 40. $\frac{1}{41}$ 41. $\frac{1}{42}$ 42. $\frac{1}{43}$ 43. $\frac{1}{44}$ 44. $\frac{1}{45}$ 45. $\frac{1}{46}$ 46. $\frac{1}{47}$ 47. $\frac{1}{48}$ 48. $\frac{1}{49}$ 49. $\frac{1}{50}$ 50. $\frac{1}{51}$ 51. $\frac{1}{52}$ 52. $\frac{1}{53}$ 53. $\frac{1}{54}$ 54. $\frac{1}{55}$ 55. $\frac{1}{56}$ 56. $\frac{1}{57}$ 57. $\frac{1}{58}$ 58. $\frac{1}{59}$ 59. $\frac{1}{60}$ 60. $\frac{1}{61}$ 61. $\frac{1}{62}$ 62. $\frac{1}{63}$ 63. $\frac{1}{64}$ 64. $\frac{1}{65}$ 65. $\frac{1}{66}$ 66. $\frac{1}{67}$ 67. $\frac{1}{68}$ 68. $\frac{1}{69}$ 69. $\frac{1}{70}$ 70. $\frac{1}{71}$ 71. $\frac{1}{72}$ 72. $\frac{1}{73}$ 73. $\frac{1}{74}$ 74. $\frac{1}{75}$ 75. $\frac{1}{76}$ 76. $\frac{1}{77}$ 77. $\frac{1}{78}$ 78. $\frac{1}{79}$ 79. $\frac{1}{80}$ 80. $\frac{1}{81}$ 81. $\frac{1}{82}$ 82. $\frac{1}{83}$ 83. $\frac{1}{84}$ 84. $\frac{1}{85}$ 85. $\frac{1}{86}$ 86. $\frac{1}{87}$ 87. $\frac{1}{88}$ 88. $\frac{1}{89}$ 89. $\frac{1}{90}$ 90. $\frac{1}{91}$ 91. $\frac{1}{92}$ 92. $\frac{1}{93}$ 93. $\frac{1}{94}$ 94. $\frac{1}{95}$ 95. $\frac{1}{96}$ 96. $\frac{1}{97}$ 97. $\frac{1}{98}$ 98. $\frac{1}{99}$ 99. $\frac{1}{100}$ 100. $\frac{1}{101}$ 101. $\frac{1}{102}$ 102. $\frac{1}{103}$ 103. $\frac{1}{104}$ 104. $\frac{1}{105}$ 105. $\frac{1}{106}$ 106. $\frac{1}{107}$ 107. $\frac{1}{108}$ 108. $\frac{1}{109}$ 109. $\frac{1}{110}$ 110. $\frac{1}{111}$ 111. $\frac{1}{112}$ 112. $\frac{1}{113}$ 113. $\frac{1}{114}$ 114. $\frac{1}{115}$ 115. $\frac{1}{116}$ 116. $\frac{1}{117}$ 117. $\frac{1}{118}$ 118. $\frac{1}{119}$ 119. $\frac{1}{120}$ 120. $\frac{1}{121}$ 121. $\frac{1}{122}$ 122. $\frac{1}{123}$ 123. $\frac{1}{124}$ 124. $\frac{1}{125}$ 125. $\frac{1}{126}$ 126. $\frac{1}{127}$ 127. $\frac{1}{128}$ 128. $\frac{1}{129}$ 129. $\frac{1}{130}$ 130. $\frac{1}{131}$ 131. $\frac{1}{132}$ 132. $\frac{1}{133}$ 133. $\frac{1}{134}$ 134. $\frac{1}{135}$ 135. $\frac{1}{136}$ 136. $\frac{1}{137}$ 137. $\frac{1}{138}$ 138. $\frac{1}{139}$ 139. $\frac{1}{140}$ 140. $\frac{1}{141}$ 141. $\frac{1}{142}$ 142. $\frac{1}{143}$ 143. $\frac{1}{144}$ 144. $\frac{1}{145}$ 145. $\frac{1}{146}$ 146. $\frac{1}{147}$ 147. $\frac{1}{148}$ 148. $\frac{1}{149}$ 149. $\frac{1}{150}$ 150. $\frac{1}{151}$ 151. $\frac{1}{152}$ 152. $\frac{1}{153}$ 153. $\frac{1}{154}$ 154. $\frac{1}{155}$ 155. $\frac{1}{156}$ 156. $\frac{1}{157}$ 157. $\frac{1}{158}$ 158. $\frac{1}{159}$ 159. $\frac{1}{160}$ 160. $\frac{1}{161}$ 161. $\frac{1}{162}$ 162. $\frac{1}{163}$ 163. $\frac{1}{164}$ 164. $\frac{1}{165}$ 165. $\frac{1}{166}$ 166. $\frac{1}{167}$ 167. $\frac{1}{168}$ 168. $\frac{1}{169}$ 169. $\frac{1}{170}$ 170. $\frac{1}{171}$ 171. $\frac{1}{172}$ 172. $\frac{1}{173}$ 173. $\frac{1}{174}$ 174. $\frac{1}{175}$ 175. $\frac{1}{176}$ 176. $\frac{1}{177}$ 177. $\frac{1}{178}$ 178. $\frac{1}{179}$ 179. $\frac{1}{180}$ 180. $\frac{1}{181}$ 181. $\frac{1}{182}$ 182. $\frac{1}{183}$ 183. $\frac{1}{184}$ 184. $\frac{1}{185}$ 185. $\frac{1}{186}$ 186. $\frac{1}{187}$ 187. $\frac{1}{188}$ 188. $\frac{1}{189}$ 189. $\frac{1}{190}$ 190. $\frac{1}{191}$ 191. $\frac{1}{192}$ 192. $\frac{1}{193}$ 193. $\frac{1}{194}$ 194. $\frac{1}{195}$ 195. $\frac{1}{196}$ 196. $\frac{1}{197}$ 197. $\frac{1}{198}$ 198. $\frac{1}{199}$ 199. $\frac{1}{200}$ 200. $\frac{1}{201}$ 201. $\frac{1}{202}$ 202. $\frac{1}{203}$ 203. $\frac{1}{204}$ 204. $\frac{1}{205}$ 205. $\frac{1}{206}$ 206. $\frac{1}{207}$ 207. $\frac{1}{208}$ 208. $\frac{1}{209}$ 209. $\frac{1}{210}$ 210. $\frac{1}{211}$ 211. $\frac{1}{212}$ 212. $\frac{1}{213}$ 213. $\frac{1}{214}$ 214. $\frac{1}{215}$ 215. $\frac{1}{216}$ 216. $\frac{1}{217}$ 217. $\frac{1}{218}$ 218. $\frac{1}{219}$ 219. $\frac{1}{220}$ 220. $\frac{1}{221}$ 221. $\frac{1}{222}$ 222. $\frac{1}{223}$ 223. $\frac{1}{224}$ 224. $\frac{1}{225}$ 225. $\frac{1}{226}$ 226. $\frac{1}{227}$ 227. $\frac{1}{228}$ 228. $\frac{1}{229}$ 229. $\frac{1}{230}$ 230. $\frac{1}{231}$ 231. $\frac{1}{232}$ 232. $\frac{1}{233}$ 233. $\frac{1}{234}$ 234. $\frac{1}{235}$ 235. $\frac{1}{236}$ 236. $\frac{1}{237}$ 237. $\frac{1}{238}$ 238. $\frac{1}{239}$ 239. $\frac{1}{240}$ 240

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

101246

154

James M. McHugh, Jr.

0007-1226

10/10/10

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 5765
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 05753

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4120 Military Road, N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>G</u> Last <u>Corey</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/71</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>			
13. FATHER'S NAME <u>John Corey</u>				14. MOTHER'S MAIDEN NAME <u>Helicia Corey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Irving M. Tuller</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemiplegia with aphasia, severe</u> DUE TO (b) <u>Arteriosclerosis, generalised, advanced</u> DUE TO (c) <u>Essential hypertension, mod severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>May 1</u> , 1961, that (I) (we) last saw the deceased alive on <u>Apr 26</u> , 1961, and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp</u>				22b. DATE SIGNED <u>May 1 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				22d. ADDRESS <u>4746 Chevy Chase Dr. Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Sp. city) <u>Buried</u>		23b. DATE THEREOF <u>5/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fair Lakes Em.</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg Rd. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chevy Chase Funeral Home</u>				25a. REC'D BY REGISTRAR <u>5703 Wisconsin Ave. Wash D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
CERTIFICATE OF DEATH

1955

(M)

(1)

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Race: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of Registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5766

CERTIFICATE OF DEATH

Reg. Dist. No. 05754

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Stoney Creek Road			
3. NAME OF DECEASED (Type or print) ROBERT E. CORNWELL				4. DATE OF DEATH Month May Day 20 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/83		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George W. Cornwell				14. MOTHER'S MAIDEN NAME Sara Ann Kidwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-8113		INFORMANT E. L. Cornwell Address 306 W. Edmonston Drive Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach DUE TO (b) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Stro		(County) Stro		(State) Stro
21. I certify that I attended the deceased from 5/16 , 19 61 , to 5/20 , 19 61 , that I last saw the deceased alive on 5/19 , 19 61 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.							DATE SIGNED 5/20/61
ACTUAL SIGNATURE Abraham W. Danish		M.D. 927 Resolving Dr.		ADDRESS (Street, city or town, state) Silver Spring, Md.			
PHYSICIAN'S NAME (Type) ABRAHAM W. DANISH		ADDRESS 927 Resolving Dr., Silver Spring, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/23/61	22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) Gaithersburg, Maryland		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.				24a. REC'D BY REGISTRAR DATE MAY 23 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1568

WV 11 3744

[Faint, mostly illegible text on a death certificate form. Visible fragments include:]

NAME: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

TIME OF DEATH: _____

CAUSE OF DEATH: _____

[Signature]

[Signature]

[Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5767

CERTIFICATE OF DEATH

Reg. Dist. No.

05755

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11118 NORLEE DR</u>		d. STREET ADDRESS <u>11118 NORLEE DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINNIE</u> First <u>COZIER</u> Middle Last		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-12-1884</u> 9. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEBANOV</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>IRWIN COZIER - 11118 NORLEE DR</u> Address <u>5576 MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan.</u> 19 <u>59</u> to <u>May 5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 30</u> , 19 <u>61</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Bernard Katzen</u> M.D. <u>3550 - Minn. Ave. S.E. S.W.</u>		PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN M.D.</u> <u>Wash. 19, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/7/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SHARRE TORAH CEM</u>	22d. LOCATION (City, town, or county) (State) <u>PITTSBURGH, PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernestine Fine</u> ADDRESS <u>4217-9th</u>		24a. REC'D BY REGISTRAR <u>MAY 8 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		12-1-28		MEMPHIS, TENN		4-4-68		MEMPHIS, TENN		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		MARRIED		HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

DO NOT WRITE IN THESE SPACES

RECEIVED BY THE REGISTRAR

DATE

TIME

PLACE

SIGNATURE

DO NOT WRITE IN THESE SPACES

RECEIVED BY THE REGISTRAR

DATE

TIME

PLACE

SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5768

05756

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>S.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>2 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>The Dresden Apt. - 202 Conn. Ave. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Margaret Elliott Craig</u>				4. DATE OF DEATH <u>May 12 19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/10/80</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			
13. FATHER'S NAME <u>William Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Eckhardt?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. W.A. Rogers</u> Address <u>5710 - 0500 K Rd. Bethesda, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420-1</u> DUE TO <u>Acute Extensive Anterior Wall Myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Coronary Atherosclerosis</u> (c) <u>24 hours</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/12/61</u> to <u>5/12/61</u> , that (I) (we) last saw the deceased alive on <u>5/12/61</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Michel M. Healy</u> M.D.				22b. DATE SIGNED <u>5/12/61</u>		22c. PHYSICIAN'S NAME (Type) <u>MICHEL M. HEALY</u>	
22d. ADDRESS <u>Washington Clinic Washington, D.C.</u>				22e. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-16-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey Funeral Home</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 18 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MICHAEL J. REILLY

Refugee, 1000 1st St. N.E., Washington, D.C.
Bethesda, Md. 20814
5-10-61 Rock Creek Cemetery, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5769

Item 7 Film G287 5/18/61 jwk

05757

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Kensington		
c. LENGTH OF STAY IN lb 45 days			d. STREET ADDRESS 1 4027 Plyers Mill Rd.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Joseph			4. DATE OF DEATH Month 5 Day 10 Year 1961		
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/8/08		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) New York State			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Samuel Crockett			14. MOTHER'S MAIDEN NAME Carolyn		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO. 327 S. Maplewood		
17. INFORMANT Bernice A. Crockett, Wife Chicago, Ill.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) confluent bronchopneumonia DUE TO (b) Multiple Emboli, Brain, Kidney DUE TO (c) Myocardial Infarction - mural thrombi PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on..... 9 May 1961, and that death occurred at.....M, from the causes and on the date stated above.					
22a. SIGNATURE Merton L. White			22b. DATE SIGNED 10 May 61		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS 11134 Georgia Ave Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/61		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial	
23d. LOCATION (City, town or county) Sandy Spring, Md		23e. LOCATION (State) Md		23f. LOCATION (Country) USA	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden			25. REGISTRY SIGNATURE Robert L. Snowden		
25a. DATE MAY 15 '61			25b. DATE MAY 15 '61		



Multiple Entries, 2 months
 100
 11/21/21

11/21/21
 11/21/21

11/21/21

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5770 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05758

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
c. LENGTH OF STAY IN 1b <i>D.O.A.</i>				d. STREET ADDRESS <i>10531- Oaklyn Drive.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mathias</i> Middle <i>Curtis</i> Last <i>Curtis</i>				4. DATE OF DEATH Month <i>May</i> Day <i>24</i> Year <i>1961</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 15, 1890</i>	
9. AGE (In years, last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months <i>40</i> Days <i>40</i>		IF UNDER 24 HRS. Hours <i>40</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer (ret.)</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>William Curtis</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes give year or dates of service) <i>World War I</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Lillian Williams</i>				Address <i>Sage 25 Above.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Coronary occlusion</i> 420.1 DUE TO (b) <i>Interval between onset and death sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>History of previous coronary disease</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschant</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>5-24-61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>5/31/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	
22d. LOCATION (City, town, or country) (State) <i>Arlington, Va.</i>							
23. FUNERAL DIRECTOR <i>Robert L. Brewster</i> ADDRESS <i>Rockville, Md.</i>				24a. REC'D BY REGISTRAR <i>MAY 29 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

MEDICAL CERTIFICATION

OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
MEDICAL DEPARTMENT
OFFICE OF THE CHIEF OF MEDICAL SERVICE
OFFICE OF THE CHIEF OF MEDICAL SERVICE
OFFICE OF THE CHIEF OF MEDICAL SERVICE

RECEIVED
JAN 10 1918
OFFICE OF THE CHIEF OF MEDICAL SERVICE

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

①

Approved: _____
Special Agent, _____
1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5771

05759

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5300 Sherrill Avenue				d. STREET ADDRESS 5300 Sherrill Avenue			
3. NAME OF DECEASED (Type or print) BESSIE ANN CUSICK				4. DATE OF DEATH May 4 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1881	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 6 Days 12	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas D. Ross				14. MOTHER'S MAIDEN NAME Ida Wood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT June C. Dowdall-daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Metastatic Carcinoma DUE TO Primary Cancer of Stomach Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH 4 mo. 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1960 to May 4, 1961 , that (I) (we) last saw the deceased alive on May 3, 1961 , and that death occurred at 5 AM , from the causes and on the date stated above.							
22a. SIGNATURE John R. Ewan				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-4-61	
22c. PHYSICIAN'S NAME (Type) JOHN R. EWAN - M.D				22d. ADDRESS 1835 Eyest. N.W. Wash. D.C			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAY 5 '61	
						25b. REGISTRAR'S SIGNATURE Winifred L. Thomas	

(M)

(I)

Don Property
Chevy Chase

3300 Sherwin II Avenue

BRISIE

ANN

UNION

Marvland
Chevy Chase

3300 Sherwin II Avenue

Female White

Nonreside

Thomas H. Ross

125 Wood

None June E. Dowdall-Danphrey-same 2d

Robert A. Humphrey Betesda, Maryland
5/3/61 Arlington, Va. 10m
Arlington, Virginia

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is 4 years of age or older, the law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5773

05761

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 36 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3313 16th Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas Louis DEGNAN		4. DATE OF DEATH May 16 1961		5. SEX Male			
6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-5-94			
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Admin. Clerk		10b. KIND OF BUSINESS OR INDUSTRY Maritime Comm.		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Degnan		14. MOTHER'S MAIDEN NAME Mary O'Brien			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1918 to 1919		17. INFORMANT Geo. Degnan, 3513 S St., NW, WashDC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma tongue with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 141.9 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 19		20g. (County) 19		20h. (State) 19			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 10, 1961 to May 16, 1961 , that we last saw the deceased alive on May 16, 1961 , and that death occurred at 7:40AM , from the causes and on the date stated above.							
22a. SIGNATURE T. E. Taylor M.D.				22b. DATE SIGNED 5-16-61			
22c. PHYSICIAN'S NAME (Type) T. E. TAYLOR, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia		23f. (Country) USA			
24. FUNERAL DIRECTOR'S SIGNATURE H. Don DeVol WashDC				25a. REC'D BY REGISTRAR MAY 18 61			
25b. REGISTRAR'S SIGNATURE Arthur S. ...				25c. DATE MAY 18 61			

1973

(M)

Montgomery

District of Columbia

Bethesda (Inver)

30 days

Washington

U. S. Naval Hospital

3313 15th Street, N. W.

Thomas

Louis

DEMAN

May

10

01

Male

Canadian

x

6-7-74

00

USA

Pennsylvania

Maritime Comm.

Admin. Clerk

(T)

Thomas Deegan

Port O'Brien

Yes 1918 to 1919 1919-20 (N) Geo. Deegan, 3313 S St., NW, Wash DC

x

May 10

01

April 10

1940

May 10

01

x

5-10-01

x

T. E. TAYLOR, LT, MC, USN

U. S. Naval Hospital, Bethesda, Md.

Burial

5-10-01

Arlington National

Arlington

Virginia

WASH DC

Devot Funeral Home, 2224 Wisconsin Ave., NW,

5774
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No. 05762

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u>	
c. LENGTH OF STAY IN 1b <u>16 years</u>		d. STREET ADDRESS <u>11 Vassar Circle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Vassar Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alfred James</u> Middle <u>DePaolis</u> Last <u>DePaolis</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 25 1899</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Giovanni DePaolis</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Bonbino</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578010028</u>	
17. INFORMANT <u>Louis DePaolis</u>		Address <u>11 Vassar Circle Glen Echo Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> 157X DUE TO <u>Carcinoma pancreas.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>9 mo.</u> (c) <u>9 mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 31, 1960</u> to <u>May 18, 1961</u> , that I last saw the deceased alive on <u>May 17, 1961</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. F. Quayle</u>		DATE SIGNED <u>May 18 1961</u>	
PHYSICIAN'S NAME (Type) <u>E. F. Quayle M.D.</u>		ADDRESS (Street, city or town, state) <u>1800 Belmont Ave. Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 22, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. De Vol</u>		24a. REC'D BY REGISTRAR <u>Wash. D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u>
ADDRESS <u>2224 W. Ave</u>		DATE <u>MAY 23 '61</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of deceased John Doe
2. Sex Male
3. Age 45
4. Date of birth Jan 15 1900
5. Place of birth St. Louis, Mo.
6. Date of death May 10 1945
7. Place of death St. Louis, Mo.
8. Cause of death Heart Disease
9. Signature of physician J. H. Smith
10. Signature of registrar W. B. Jones
11. Date of registration May 12 1945
12. Office of registration St. Louis, Mo.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06908**

WT. **5775** 12 in. long.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 16	d. STREET ADDRESS 15723 OGDEN Rd.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last DERRY		4. DATE OF DEATH Month MAY Day 25 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1961
9. AGE (In years last birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 	10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) MARYLAND
--	--	---

12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME JOHN ALVIN DERRY
--	---

14. MOTHER'S MAIDEN NAME MILDRED VIRGINIA KRIEG	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 	16. SOCIAL SECURITY NO.
--	---	------------------------------------

17. INFORMANT MOTHER		Address SAME AS ABOVE
---------------------------------------	--	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH
--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--	---

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
--	--	---	---

21. I certify that I attended the deceased from 5/23 , 19 61 , to 5/25 , 19 61 , that I last saw the deceased alive on 5/25 , 19 61 , and that death occurred at 3:50 A M, from the causes and on the date stated above.		DATE SIGNED
--	--	--------------------

ACTUAL SIGNATURE Dr. J. Pearlman M.D.	ADDRESS (Street, city or town, state)
--	--

PHYSICIAN'S NAME (Type) 	22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 5/27/61	22c. NAME OF CEMETERY OR CREMATORY SUBURBAN HOSPITAL
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23. FUNERAL DIRECTOR'S SIGNATURE Amelia Carter	24a. REC'D BY REGISTRAR DATE JUN 12 '61	24b. REGISTRAR'S SIGNATURE William S. Hanna
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24c. ADDRESS OLD GEORGETOWN RD, BETHESDA, MARYLAND	24d. LOCATION (City, town, or county) (State) BETHESDA, MARYLAND
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

274411XV0

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5776

05763

1. PLACE OF DEATH a. COUNTY <div style="font-size: 1.2em; font-weight: bold;">MONTGOMERY</div> <div style="text-align: right; font-weight: bold;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <div style="font-size: 1.2em; font-weight: bold;">MARYLAND</div> b. COUNTY <div style="font-size: 1.2em; font-weight: bold;">PRINCE GEORGES</div>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="font-size: 1.2em; font-weight: bold;">BETHESDA</div>		c. LENGTH OF STAY in 1b <div style="font-size: 1.2em; font-weight: bold;">14 days</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="font-size: 1.2em; font-weight: bold;">BELTSVILLE</div>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="font-size: 1.2em; font-weight: bold;">Suburban Hospital</div>				d. STREET ADDRESS <div style="font-size: 1.2em; font-weight: bold;">4501 Brandon Lane</div>			
3. NAME OF DECEASED (Type or print) <div style="font-size: 1.2em; font-weight: bold;">Agnes Irene Dodd</div>				4. DATE OF DEATH Month Day Year <div style="font-size: 1.2em; font-weight: bold;">MAY 18 1961</div>			
5. SEX <div style="font-size: 1.2em; font-weight: bold;">F</div>		6. COLOR OR RACE <div style="font-size: 1.2em; font-weight: bold;">W</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <div style="font-size: 1.2em; font-weight: bold;">Feb. 9, 1881</div>		9. AGE (In years last birthday) <div style="font-size: 1.2em; font-weight: bold;">80 yrs.</div>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em; font-weight: bold;">SEAMSTRESS - HSWF.</div>				10b. KIND OF BUSINESS OR INDUSTRY <div style="font-size: 1.2em; font-weight: bold;">PRIVATE</div>			
11. BIRTHPLACE (County & State, or foreign country) <div style="font-size: 1.2em; font-weight: bold;">No. Thumberland Co., Va.</div>				12. CITIZEN OF WHAT COUNTRY? <div style="font-size: 1.2em; font-weight: bold;">U.S.A</div>			
13. FATHER'S NAME <div style="font-size: 1.2em; font-weight: bold;">UNKNOWN? - BRYANT</div>				14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em; font-weight: bold;">UNKNOWN</div>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <div style="font-size: 1.2em; font-weight: bold;">NO</div>		16. SOCIAL SECURITY NO. <div style="font-size: 1.2em; font-weight: bold;">NONE</div>		17. INFORMANT Address <div style="font-size: 1.2em; font-weight: bold;">William H. Richards (son) as above</div>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Irreversible shock</p> <p>466X Pulmonary embolism</p> <p>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.</p> <p>Peripheral venous thrombosis</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>2 hours</p> <p>2 hours</p> <p>unknown</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="font-size: 1.2em; font-weight: bold;">19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <div style="font-size: 1.2em; font-weight: bold;">5/16, 1961</div>			
20f. (City or town) <div style="font-size: 1.2em; font-weight: bold;">5/18, 1961</div>		(County) 		(State) 			
21. I certify that (I) (this hospital) attended the deceased from 5/16, 1961 to 5/18, 1961 that (I) (we) last saw the deceased alive on 5/18, 1961 and that death occurred at 7:55 PM from the causes and on the date stated above.							
22a. SIGNATURE <div style="font-size: 1.2em; font-weight: bold;">Abraham W. Danish</div>				22b. DATE SIGNED <div style="font-size: 1.2em; font-weight: bold;">5/19/61</div>			
22c. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em; font-weight: bold;">ABRAHAM W. DANISH</div>				22d. ADDRESS <div style="font-size: 1.2em; font-weight: bold;">927 Pershing Dr. Silver Spring, Md</div>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em; font-weight: bold;">Burial</div>		23b. DATE THEREOF <div style="font-size: 1.2em; font-weight: bold;">May 22, 1961</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="font-size: 1.2em; font-weight: bold;">George Washington Comm Inc</div>			
23d. LOCATION (City, town or county) <div style="font-size: 1.2em; font-weight: bold;">Hyattsville, Md.</div>		(State) 					
24. FUNERAL DIRECTOR'S SIGNATURE <div style="font-size: 1.2em; font-weight: bold;">W. M. Chambers</div>				25a. REC'D BY REGISTRAR <div style="font-size: 1.2em; font-weight: bold;">DATE 5 MAY 22 '61</div>			
25b. REGISTRAR'S SIGNATURE <div style="font-size: 1.2em; font-weight: bold;">Arthur S. Kraus</div>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, & 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>			
c. LENGTH OF STAY IN 1b. <u>3 wks</u>				d. STREET ADDRESS <u>8119 Hammond Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Stella</u>		First <u>Stella</u> Middle <u>Viretta</u> Last <u>Dodd</u>		4. DATE OF DEATH <u>5</u> / <u>1</u> / <u>1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/6/44</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Patton</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Coler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Chart Record at Hospital</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Arteriosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH. <u>2 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> / <u>1961</u> to <u>5/1</u> / <u>1961</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>5/1</u> / <u>1961</u> , and that death occurred at <u>10:23</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Eino Magi</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				22d. ADDRESS <u>918 Univ. Blvd. E., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Leiers, Sons Co</u>				ADDRESS <u>3605-14 & Ave</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 3 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

Wash. D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5778

05765

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen. Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md. 16542</u> d. STREET ADDRESS <u>7804 Lockney Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Louis Michael Dorsch</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1961</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-79</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Michael Dorsch</u>			14. MOTHER'S MAIDEN NAME <u>Catherine (Unknown)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-6745</u>		17. INFORMATION <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Myocardial Insufficiency</u> (c) <u>Old Coronary Atherosclerosis due to Arteriosclerosis?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Supra-Pubic Prostatectomy 5-3-61</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>3 hrs.</u>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that (I) (the doctor) attended the deceased from <u>April 16, 1961</u> to <u>May 4, 1961</u>, that (I) <u> </u> last saw the deceased alive on <u>May 4, 1961</u>, and that death occurred at <u> </u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul E. Fanet</u> M.D.		22b. ADDRESS <u>6727-16th St. N.W. Wash DC</u>		22c. DATE SIGNED <u>5-4-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAUL FANET</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 8, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince George County Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey Inc</u>		ADDRESS <u>Silver Spring Md.</u>		25a. REC'D BY REGISTRAR <u> </u>	25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>		

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History

200-5745

Prince George County, Va.

Fort Lincoln Cemetery

May 1, 1961

Letter

James H. Smith

June 1, 61

Page

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5778 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05766

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY in 1b <u>6 yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Rockville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1910 Rockland Ave</u>			d. STREET ADDRESS <u>1910 Rockland Ave</u>		
3. NAME OF DECEASED (Type or print) <u>Alyse Margaret Dougherty</u>			4. DATE OF DEATH <u>May 22 1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-1897</u> <u>63</u> yrs.		9. AGE (In years, last birthday) <u>63</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Unknown Clark</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>James J. Dougherty (husband)</u> <u>Stu</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> 153.8 DUE TO (b) <u>Carcinoma of lower bowel with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>6 yrs.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D.		DATE SIGNED <u>5-22-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial-Transit		May 26, 1961		West Laurel Hills Cemetery Montgomery County Philadelphia	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue</u>		24a. REC'D BY REGISTRAR	
<u>Raymond A. Liska</u>		<u>Silver Spring, Md.</u>		DATE <u>MAY 26 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

VS. A15ME
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

RECEIVED
MAY 25 1961
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

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MAY 25 1961
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5780

05787

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cabin John</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>586806 - 7 Locks Rd</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6806 7 Locks Rd</i>				d. STREET ADDRESS <i>1 Cabin John</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lola</i> Middle <i>Ellen</i> Last <i>Dove</i>				4. DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 20, 1894</i>		9. AGE (In years last birthday) <i>66</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lloyd T Jackson</i>				14. MOTHER'S MAIDEN NAME <i>Not Known</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Solera Snowden Dove</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarct</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Arteriosclerosis</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i>							INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i> <i>5 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1961</i> to <i>May 13, 1961</i> , that (I) (we) last saw the deceased alive on <i>May 11, 1961</i> , and that death occurred at <i>3:05 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>William H Killay</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>William H Killay</i>				22d. ADDRESS <i>8218 Wisconsin Ave Bethesda MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/17/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moses Cemetery.</i>		23d. LOCATION (City, town, or county) (State) <i>Cabin John, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				ADDRESS <i>Rockville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 19 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

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CERTIFICATE OF DEATH

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MARYLAND-STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05768

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Germantown		c. LENGTH OF STAY IN 1b 20 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Germantown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle ELLEN Last DOVE				4. DATE OF DEATH Month MAY Day 13 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-1884		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sanford R. Miller				14. MOTHER'S MAIDEN NAME Virginia (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Woodrow Dove, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO-RENAL FAILURE DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA DUE TO (c) CARCINOMA OF THE STOMACH							INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 6 MONTHS 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LEFT HEMIPLEGIA HYPERTENSION							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from June 1949 to May 13, 1961 , that (I) (we) last saw the deceased alive on 12 MAY 1961 , and that death occurred at 10AM , from the causes and on the date stated above.							
22a. SIGNATURE John Fawcett				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John Fawcett				22d. ADDRESS DAWSONVILLE P.O. Box D, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Luke's Lutheran		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				25a. REC'D BY REGISTRAR DATE MAY 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. King	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5782											
CERTIFICATE OF DEATH											
05769											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6608 Rannoch Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WALLACE J DUGAS						4. DATE OF DEATH Last MAY 22 Month 19 Day 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/29/10		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 1 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Br. Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Frick Co.				11. BIRTHPLACE (County & State, or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Ernest Dugas				14. MOTHER'S MAIDEN NAME Celina Daigel				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Isabella Dugas Wife (Same as above)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct. Art 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Moderate Arterio Sclerosis (c) Moderate Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Fibrotic Emphysema & Asthma INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days 5 years 2 years											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from May 18, 1961 to May 22, 1961 , that (I) (we) last saw the deceased alive on May 21, 1961 , and that death occurred at 9:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE Gilbert B. Rude M.D.											
22b. DATE SIGNED 5-22-61											
22c. PHYSICIAN'S NAME (Type) Gilbert B. Rude											
22d. ADDRESS 3900 Military rd NW DC											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 5/25/61											
23c. NAME OF CEMETERY OR CREMATORY Burns Hill Cemetery											
23d. LOCATION (City, town or county) (State) Waynsboro, Pennsylvania											
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey											
ADDRESS Bethesda, Maryland											
25a. REC'D BY REGISTRAR MAY 25 '61											
25b. REGISTRAR'S SIGNATURE Carlton S. Kraus											

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(I)

Robert A. Campbell, Bethesda, Maryland
James Hill Cemetery, Waynesboro, Pennsylvania
March 25, 1911

Dear Mr. Campbell:
I have just received your letter of the 22nd inst. in regard to the matter of the burial of the remains of the late Mrs. Mary Hill Campbell. I am sorry that I cannot give you a more definite answer at this time, but I am sure that the matter will be settled to your satisfaction.

Very truly,
Robert A. Campbell

Enclosed for you are the following documents:
1. A copy of the certificate of death of the late Mrs. Mary Hill Campbell.
2. A copy of the certificate of burial of the late Mrs. Mary Hill Campbell.

Very truly,
Robert A. Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Dist. of Co.</i> b. COUNTY <i>Washington</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>					c. LENGTH OF STAY IN 1b <i>12 hrs. 10 min.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>					d. STREET ADDRESS <i>3117-45th St.</i>				
3. NAME OF DECEASED (Type or print) GEORGE HARRISON DURAND					DATE OF DEATH <i>May 19 1961</i>				
5. SEX <i>male</i> COLOR OR RACE <i>white</i>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>					11. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>				
13. FATHER'S NAME <i>Cyrus Gale Durand</i>					12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>					16. SOCIAL SECURITY NO. <i>no</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Failure</i> 428-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Atherosclerosis Heart Disease</i> DUE TO (c) <i>4 yrs</i>					INTERVAL BETWEEN ONSET AND DEATH <i>Several days</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>May 19 1961</i> to <i>May 19 1961</i> , that (I) (was) last saw the deceased alive on <i>May 19 1961</i> , and that death occurred at <i>5:50 PM</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Michael A. Haly MD</i>					22b. DATE SIGNED <i>5/19/61</i>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS <i>Washington Clinic, Washington, D.C.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>					23b. DATE THEREOF <i>5/22/61</i>				
23c. NAME OF CEMETERY OR CREMATORY <i>Yankton Cemetery</i>					23d. LOCATION (City, town or county) (State) <i>South Dakota</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. Hines Co</i>					25a. REC'D BY REGISTRAR <i>2901-14 ST. W. Wash. D.C.</i>				
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>					DATE <i>MAY 22 '61</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05771

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL) Garrett Park c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11013 Montrose Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park d. STREET ADDRESS 11013 Montrose Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First LEON Middle Lamar Last DYE		4. DATE OF DEATH Month May Day 20 Year 19 61		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 21, 1871 9. AGE (In years 89 birthday) yrs. 12 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Major USMC 11. BIRTHPLACE (State or foreign country) Miss. 12. CITIZEN OF WHAT COUNTRY? USA	
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13. FATHER'S NAME Thomas Jefferson Dye		14. MOTHER'S MAIDEN NAME Leticia Longmire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1 and 2 None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Bethesda, Md. Williston L. Dye-son-9709 Bellevue Drive			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Cornary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5-20-61	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/61		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 23 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Huns							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05772

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 25 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPENCERVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 1 -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ADOLPHUS (NMN) EDWARDS				4. DATE OF DEATH Month Day Year MAY 6 19 61			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-92	
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN				10b. KIND OF BUSINESS OR INDUSTRY BD. OF EDUCATION		11. BIRTHPLACE (State or foreign country) NEBRASKA	
13. FATHER'S NAME JAMES EDWARDS				14. MOTHER'S MAIDEN NAME MATTIE JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary and Cerebral Emboli 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mural Thrombus DUE TO (c) Myocardial Infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 wks 1) 3 wks 2) 3 months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 11 19 61 to MAY 6 1961 , that (I) (we) last saw the deceased alive on MAY 6 19 61 , and that death occurred at 12:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert A. Yates M.D.				22b. DATE SIGNED 5/6/61		22c. PHYSICIAN'S NAME (Type) R.A. YATES, M.D.	
22d. ADDRESS OLNEY, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National.,		23d. LOCATION (City, town, or county) (State) Arlington, Va..	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surwood				ADDRESS Rockville, Md.		25a. RECEIVED BY REGISTRAR DATE MAY 10 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5786

CERTIFICATE OF DEATH

05773

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY in 1b <i>11 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>211 E Khan Allen Ave.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium & Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Edward</i> Middle <i>Edwards</i> Last		4. DATE OF DEATH <i>5</i> <i>9</i> <i>1961</i>					
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-17-73</i>	9. AGE (In years last birthday) <i>87</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>minister</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Sweden</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>John Edwards</i>		14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> 420.0 DUE TO Condition <i>gave rise to immediate cause</i> (b) <i>Congestive heart failure</i> (c) <i>Arteriosclerotic heart disease</i> cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Diabetes mellitus</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <i>4/29</i> , 19 <i>61</i> , to <i>5/9</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>5/9</i> , 19 <i>61</i> , and that death occurred at <i>6</i> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <i>Eino Magi</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5/9/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		22d. ADDRESS <i>918 Univ. Blvd. E. Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 12, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>	23d. LOCATION (City, town or county) <i>Prince George County, Md.</i> (State)				
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St. NW L.C.</i>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Finna</i>		
				DATE <i>MAY 12 '61</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5787

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05774

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 10 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookeville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital			d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roland Middle Mason Last Fennington			4. DATE OF DEATH Month May Day 13 Year 19 61		
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/1888	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Heavy Construction		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Fennington			14. MOTHER'S MAIDEN NAME Annie Nicholson Huff		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Russell Bryan Address Brookeville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blood loss shock (internal bleeding) DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable rupture of abd. aortic aneurysm DUE TO Arteriosclerotic Cardiovascular Disease (c) Interval between ONSET and DEATH - 2 days					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/13/1961 to 5/13/1961 that (I) (we) last saw the deceased alive on 5/13/1961 and that death occurred at 4:35 PM from the causes and on the date stated above.					
22a. SIGNATURE John P. Martin		22b. DATE SIGNED May 14, 1961		22c. PHYSICIAN'S NAME (Type) JOHN P. MARTIN, MD	
22d. ADDRESS SANDY SABINE, MD		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 17, 1961		23c. NAME OF CEMETERY OR CREMATORY Brookeville	
23d. LOCATION (City, town, or county) Brookeville, Md.		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 16 '61	
25b. REGISTRAR'S SIGNATURE Anthony S. Kline		25c. (State)			

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Page 4
After death.
The law requires that the death certificate be executed within 24 hours after death.
The attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
Item 6 Film G286 5/11/61 ink															
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium, 5721 Grosvenor La.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 4118 49th St. N.W.							
3. NAME OF DECEASED (Type or print) First Elizabeth Middle T. Last Fisher.				4. DATE OF DEATH Month May Day 6 Year 1961											
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18 1878		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82		IF UNDER 24 HRS. Days 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY				10b. KIND OF BUSINESS OR INDUSTRY RETIRED				11. BIRTHPLACE (State or foreign country) Iowa				12. CITIZEN OF WHAT COUNTRY? A. U.S.			
13. FATHER'S NAME George F. Fisher						14. MOTHER'S MAIDEN NAME Mary E. Orr									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. ---				17. INFORMANT John W. Fisher, 4118 49th St, NW				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 232X DUE TO (c) 22mo years												INTERVAL BETWEEN ONSET AND DEATH 22mo years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington		(County) Iowa		(State) Iowa			
21. I certify that (I) (this hospital) attended the deceased from Feb. 24, 1961 to May 5, 1961 , that (I) (we) last saw the deceased alive on May 5, 1961 , and that death occurred at 10:50 P.M. from the causes and on the date stated above.															
22a. SIGNATURE C. P. Ryland				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 5-6-61							
22c. PHYSICIAN'S NAME (Type) C. P. RYLAND				22d. ADDRESS 4400-49 St NW Washington DC											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/10/1961		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) Washington, Iowa		(State) Iowa					
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Bowler's Sons, Washington, D. C.						25a. REC'D BY REGISTRAR DATE MAY 9 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Thoms							



ATTEST: I, _____
Notary Public for the State of _____
My Commission Expires _____

NOTARY PUBLIC

WITNESSES: _____
Subscribed and sworn to before me this _____ day of _____, 20____.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05778

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8600 Greenwood Ave 19</u>			
c. LENGTH OF STAY IN 1b <u>16 hours</u>				d. STREET ADDRESS <u>Takoma Park 12 Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Garfield</u> Last <u>Fowler</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-81</u>	
9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BULLARD MFG. Co.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George W. Fowler</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE BURNS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>041-10-0131</u>			
17. INFORMANT <u>W.S. Hosp. Records</u>				Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> 52711 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Emphysema ; Chronic lung disease</u> (a), stating the underlying cause last. DUE TO (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-6</u> , 19 <u>57</u> , to <u>5/19</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>MAY 19 1961</u> , and that death occurred at <u>12:35 P.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. Leonard Gold</u> M.D.				22b. DATE SIGNED <u>5/19/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold</u>				22d. ADDRESS <u>8641 Colesville Road, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial-Transit 5/22/61</u>		<u>5/22/61</u>		<u>Lawncroft Cemetery</u>		<u>Fairfield Connecticut</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond A. Ziska</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 23 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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UNITED STATES GOVERNMENT
BUREAU OF INDIAN AFFAIRS
WASHINGTON, D. C. 20540

UNITED STATES GOVERNMENT

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UNITED STATES GOVERNMENT

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Embryonic (Crown and Nerve
A-ate mesoderm tissue
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21/1/61

21/1/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5790

05777

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Montana</i> b. COUNTY <i>Lewis & Clark</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Helena</i>	
c. LENGTH OF STAY IN 1b <i>11 mo 23 da</i>		d. STREET ADDRESS <i>None</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jennie</i> Middle <i>W</i> Last <i>Graham</i>		4. DATE OF DEATH Month <i>May</i> Day <i>31</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 31, 1878</i>
9. AGE (In years lost birthday) <i>83</i> yrs.		10. UNDER 1 YEAR Months <i>4</i> Days <i>14</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>N. W.</i>		11. BIRTHPLACE (State or foreign country) <i>England</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		13. FATHER'S NAME <i>John Whyatt</i>	
14. MOTHER'S MAIDEN NAME <i>Jane Seldon</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>James D. Graham, Jr.</i> Address <i>Bethesda, Md 6007 Goldsboro Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic failure</i> DUE TO (b) <i>Carcinomatosis, generalized</i> DUE TO (c) <i>Adenocarcinomatosis of breast left</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>170X</i>		INTERVAL BETWEEN ONSET AND DEATH: <i>2 wks</i> <i>3 months</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1960</i> to <i>31 May 1961</i> that (I) (we) last saw the deceased alive on <i>27 May 1961</i> , and that death occurred at <i>9:15 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Herbert Martyn Jr</i>		22b. DATE SIGNED <i>31 May 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>HERBERT MARTYN JR</i>		22d. ADDRESS <i>5029 Bethesda Ave</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-transit</i>		23b. DATE THEREOF <i>6/1/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mountain View Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Livingston, Montana</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		25a. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	
25b. REC'D BY REGISTRAR <i>JUN 2 '61</i>		25c. DATE	

M

State of Massachusetts
County of Suffolk
City of Boston
I, John J. [illegible], Registrar of Vital Records,
do hereby certify that on the 10th day of April,
1914, at the City of Boston, in the County of Suffolk,
State of Massachusetts, John J. [illegible],
aged 45 years, of the County of Suffolk,
State of Massachusetts, died at his late residence,
at the City of Boston, in the County of Suffolk,
State of Massachusetts, of Heart Disease,
after a illness of several days.
The death was caused by Heart Disease,
and was not the result of any violence,
suicide, or any other unlawful cause.
The death was reported to me by John J. [illegible],
of the City of Boston, in the County of Suffolk,
State of Massachusetts.

Witness my hand and the seal of the Department of Health
at the City of Boston, in the County of Suffolk,
State of Massachusetts, this 10th day of April,
1914.
John J. [illegible], Registrar of Vital Records.
Attest:
[Signature]
[Signature]
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5791

05778

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4605 Wilwyn Way		d. STREET ADDRESS Box 52	
3. NAME OF DECEASED (Type or print) First Clara Middle Angeline Last Griffith		4. DATE OF DEATH Month May Day 30 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1866
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post mistress, ret		10b. KIND OF BUSINESS OR INDUSTRY Post Office	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Porter Griffith		14. MOTHER'S MAIDEN NAME Margaret Virginia Keys	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ruth G. Veirs-Box 52-Rockville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) 422.1 DUE TO (c) 422.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) cardiovascular accident - cerebral thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 17, 1957 to May 30, 1961 , that (I) (ma) last saw the deceased alive on May 29, 1961 , and that death occurred at 12 PM , from the causes and on the date stated above.			
22a. SIGNATURE Stephen C. Cromwell M.D.		22b. DATE SIGNED 5-30-61	
22c. PHYSICIAN'S NAME (Type) Stephen C. Cromwell		22d. ADDRESS Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/61	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR JUN 2 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE C. S. Jones	



Post Office

Rockville

Box 52

State

Post Office

Rockville

Box 52

State

Post Office

Oct. 19, 1966

Female

USA

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Antrodia curvicaulis

Antrodia curvicaulis

None

Oct. 17 57 May 30 61

May 27 61

Antrodia curvicaulis

Post Office

2-30-61

Rockville, MD

Post Office

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5792

05779

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>11 1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3932 Morrison St, NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Armand</u> Middle <u>Lewellyn</u> Last <u>Griggs</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8, 1909</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>meteorologist U.S. Weather Bur.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Irving Griggs</u>				14. MOTHER'S MAIDEN NAME <u>Alta H. Schindler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or, unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>MRS. ELIZ. Griggs - AS ABOVE</u>			
17. INFORMANT <u>MRS. ELIZ. Griggs - AS ABOVE</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Myocardial INFARCT</u> <u>430-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Thrombosis, Right Coronary Artery</u> (c) <u>Arteriosclerosis</u> cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/27/1961</u> , to <u>5/27/1961</u> , that (I) (we) last saw the deceased alive on <u>5/27/1961</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stephen H. Jones</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/27/61</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Varner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
25b. REGISTRAR'S SIGNATURE				DATE <u>JUN 6 '61</u>			

(M)

(I)

No

Trinity College

Miss E. L. Gidds - A. L. Gidds

MAY 2, 1922

Washington, D. C.

MAY 2, 1922

3934 Wisconsin Ave., N.W.

Washington, D. C.

May 2, 1922

May 2, 1922

May 2, 1922

Trinity College, Hartford, Conn.
Rev. E. L. Gidds, A. L. Gidds
3934 Wisconsin Ave., N.W.
Washington, D. C.

5793

CERTIFICATE OF DEATH

Reg. Dist. No. 05780

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK

c. LENGTH OF STAY IN 1b 57 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE PENNA b. COUNTY LEWISBURG

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEWISBURG

d. STREET ADDRESS 75X-2

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last MARY JANE GROOVER

4. DATE OF DEATH Month Day Year 5 29 1961

5. SEX FEMALE 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 10.26.83 9. AGE (In years last birthday) 77 yrs. 10. IF UNDER 1 YEAR Months 7 Days 3 Hours 3 Min. 11. IF UNDER 24 HRS. Months 7 Days 3 Hours 3 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home-maker 11. BIRTHPLACE (State or foreign country) PENNA 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME J. Gundy Wolfe 14. MOTHER'S MAIDEN NAME Anna Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ☐ If yes, give war or dates of service ☐ 16. SOCIAL SECURITY NO. WASHINGTON SANITARIUM & HOSPITAL RECORDS

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Syphilis Abdominal (Hogden)
201X DUE TO (b) known possibility 6 3/4 months
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) Septicemia
a. Septicemia, Apr 1961

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While of work ☐ Not while of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/29/61 to 5/29/61, that I last saw the deceased alive on 5/29/61, and that death occurred at 10:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Howard T. Morse M.D. ADDRESS (Street, city or town, state) 7030 Carpenter Ave. Takoma Park Md DATE SIGNED 5/29/61

PHYSICIAN'S NAME (Type) HOWARD T. MORSE

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 5/29/1961 22c. NAME OF CEMETERY OR CREMATORY LEWISBURG, PENNSYLVANIA 22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE HYSONG FUNERAL HOME ADDRESS 1300 N. STREET, N.W. WASHINGTON, D.C. 24a. REC'D BY REGISTRAR MAY 31 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5794 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05781											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>83X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>2410 No 11th ST.</u>					
3. NAME OF DECEASED (Type or print) <u>Linda Lee Haas</u>			4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1961</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-23-08</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>31</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.O.L.</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Lee cheely</u>						14. MOTHER'S MAIDEN NAME <u>Linda Hawks</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>3-84-01</u>		17. INFORMANT <u>Mr. R.V. Jones - Brother in law</u> Address <u>Same Address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEVERE CORONARY ARTERY ARTERIOSCLEROSIS WITH THROMBOSIS</u> DUE TO (c) <u>days</u>										INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>a.m.</u> <u>p.m.</u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>5-31-61</u>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-3-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>COLUMBIA GARDENS</u>				22d. LOCATION (City, town, or country) (State) <u>ARLINGTON VA</u>			
23. FUNERAL DIRECTOR <u>Ives Funeral Home, Inc.</u> ADDRESS <u>ARLINGTON, VA</u>						24a. REC'D BY REGISTRAR <u>JUN 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

100-2111
M

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

RE: [Illegible]

[Illegible text in memorandum body]

FOR STATE HEALTH DEPT

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5795

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65782

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>md</i>	b. COUNTY <i>mmty</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Silver Spring</i>	d. STREET ADDRESS <i>1 W. Franklin St</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>W. Franklin St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4. DATE OF DEATH Month <i>5</i> Day <i>28</i> Year <i>1961</i>	5. SEX <i>male</i>
3. NAME OF DECEASED (Type or print) <i>William</i>	First <i>COLON</i>	Last <i>Hall</i>	6. COLOR OR RACE <i>white</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 11, 1891</i>	9. AGE (In years last birthday) <i>70</i> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CONSTRUCTION WORKER</i>
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Mr. William Thomas Hall</i>	14. MOTHER'S MAIDEN NAME <i>Mrs. Susan Tippet</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>579-03746</i>	17. INFORMANT <i>Baltimore, Maryland</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DISEASE WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> 491X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Mucoid Obstruction of Bronchi</i> DUE TO (c) <i>Pneumonia</i>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/31/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>	22d. LOCATION (City, town, or country) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc., 8434 Georgia Avenue Silver Spring, Maryland</i>	24a. REC'D BY REGISTRAR <i>UN 5 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	DATE SIGNED <i>5-29-61</i>

THE RIGHT
HONORABLE
MEMBER

M

James Thompson, Esq.,
1000 Broadway, New York
City, N. Y.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with permit PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13 & 14 Film G288 6/15/61 jwx

05783

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in lb <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>723 Boundary Ave</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1723 Boundary Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Samuel Homer Hamblin</u> First Middle Last 4. DATE OF DEATH <u>May 21 1961</u> Month Day Year			5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-19-11</u> 9. AGE (In years last birthday) <u>49</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blumberg</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Va (Polaski County)</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>unknown</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>224-10-5050</u> 17. INFORMANT <u>MRS. HELEN NESTER HAMBLIN (wife)</u> Address <u>c/o Devilbliss Funeral Home, Radford Va.</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Found dead on floor at home</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-21-61</u>		
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u> Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>5/24/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>SIFFORD CEMETERY</u> 22d. LOCATION (City, town, or country) (State) <u>PULASKI COUNTY, VA.</u>			23. FUNERAL DIRECTOR <u>Warner E. Humphrey Inc</u> ADDRESS <u>8434 S. S. Hwy</u> 24a. REC'D BY REGISTRAR <u>MAY 23 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

MEDICAL CERTIFICATION

(M)

(D)

(S)

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5797

05784

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Harrison			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4727 Boiling Brook Pkwy.				d. STREET ADDRESS 85X-1			
3. NAME OF DECEASED (Type or print) First Lot Middle P Last Hansford				4. DATE OF DEATH Month May Day 24 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1877	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR 3 Months 6 Days		IF UNDER 24 HRS. 6 Hours 19 Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Company				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Francis H. Hansford			
14. MOTHER'S MAIDEN NAME Victoria Barnette				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Louise Osborne-Daughter-same 1d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) PROSTATIC HYPERTROPHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 MOS 2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 8 19 61 , to MAY 24 19 61 , that (I) was lost saw the deceased alive on MAY 24 19 61 , and that death occurred at 8:27A M, from the causes and on the date stated above.							
22a. SIGNATURE Edward A. Beeman				22b. DATE SIGNED MAY 24, 1961			
22c. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN				22d. ADDRESS 10620 GEORGIA AVE. SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		23b. DATE THEREOF 5/27/61		23c. NAME OF CEMETERY OR CREMATORY Elks View Masonic Cem.		23d. LOCATION (City, town, or county) (State) Clarksburg, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAY 25 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1947

STATE OF TEXAS

1947

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County of ...

Rocky ...

Rocky ...

Loc ...

Warrant ...

CA ...

No. ...

Case ...

San Antonio ...

Admitted ...

San Antonio ...

Charles H. ...

Victoria ...

None

Charles ...

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05785

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6914 Seven Locks Road</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Edward Hart</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27 1920</u>	
9. AGE (in years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Col</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Hart</u>		14. MOTHER'S MAIDEN NAME <u>Mary Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>05785</u>	
17. INFORMANT <u>Dorothy Hart (Wife) Same as above</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> <u>434.4</u> DUE TO (b) <u>myocardial hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cor pulmonale</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Brochant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-31-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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[Faint, illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5795

05786

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1658-2</u> d. STREET ADDRESS <u>6900 23rd Avenue</u>																											
3. NAME OF DECEASED (Type or print) <u>Mr. James Moore Hartley</u> First Middle Last 4. DATE OF DEATH <u>May 5 1961</u> Month Day Year				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 12, 1881</u> <u>80</u> yrs.		9. AGE (In years, last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bank Clerk, Nat. Bk. of Wash.</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (Country & State, or foreign country) <u>District of Columbia U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY?																			
13. FATHER'S NAME <u>Joseph Hartley</u>				14. MOTHER'S MAIDEN NAME <u>Emily Cook</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>577-22-1690</u>						17. INFORMANT <u>Washington Sanitarium and Hospital Records</u> Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 260X DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic pyelonephritis</u> (c) <u>arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 yrs</u>														PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																			
21. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> , 19 <u>61</u> , to <u>5/4</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/4</u> , 19 <u>61</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.														22a. SIGNATURE <u>Wayne Clickfield</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5/5/61</u>																	
22c. PHYSICIAN'S NAME (Type) <u>WAYNE CLICKFIELD</u>				22d. ADDRESS <u>6826 Riggs Rd. Hyattsville</u>																											
23a. BURIAL, CREMATION, or other disposal (Specify) <u>burial</u>				23b. DATE THEREOF <u>5/9/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Nat. Mem. Park Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Falls Church, Virginia</u>																			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				ADDRESS <u>Wash, D.C.</u>				25a. REC'D BY REGISTRAR <u>MAY 8 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>																			

(M)

Chief Clerk

James L. ...

Secretary of the Board

Mr. James L. ...

February 12, 1912

White

Re: ...

Joseph H. ...

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Ernest Cook

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State of Columbia, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>							
c. LENGTH OF STAY IN 1b <u>1 day</u>						d. STREET ADDRESS <u>4840 Ft. Totten dr. N.E.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Saint + Hospt.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Fern</u> Middle <u>Collie</u> Last <u>Harvey</u>						4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1961</u>							
5. SEX <u>Fe.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-1907</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>31</u> Days <u>19</u> Hours <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S.W.F.</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>					
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>				13. FATHER'S NAME <u>Spencer Abbott</u>				14. MOTHER'S MAIDEN NAME <u>Fern Prather</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Joseph C. Harvey</u> <u>Husband</u> Address <u>Same # 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic coma</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>30</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5/30/61</u> , 19 <u>61</u> , to <u>5/31/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/31/61</u> , 19 <u>61</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>A.W. Smith</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/31/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>						22d. ADDRESS <u>13018 GEORGIA AVE W HEATON, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>St. H. Hines Co</u>						ADDRESS <u>2901 145th NW</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

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Joseph C. Harvey

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TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
5801													
05788													
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>736 Bethesda</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>1 Gaithersburg</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>5 suburban</i>						d. STREET ADDRESS <i>35 Westland St</i>							
3. NAME OF DECEASED (Type or print) <i>Nettie A Heffner</i>						4. DATE OF DEATH <i>May 29 1961</i>							
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/13/98</i>		9. AGE (In years, last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>Frank Nichols</i>						14. MOTHER'S MAIDEN NAME <i>Sally Nichols</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>						16. SOCIAL SECURITY NO. <i>512-N. Henrietta Lane</i>		17. INFORMANT <i>Marie Thompson</i> <i>Rockville, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> <i>cerebral vascular accident</i> DUE TO (b) <i>arteriosclerosis</i> DUE TO (c) <i>generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>diabetes mellitus & uremia</i>												INTERVAL BETWEEN ONSET AND DEATH <i>30'</i> <i>unknown</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 1, 1953</i> to <i>5/29/1961</i> , that (I) (we) last saw the deceased alive on <i>5/29/1961</i> , and that death occurred <i>at 10:10 PM</i> from the causes and on the date stated above.													
22a. SIGNATURE <i>Dr. John M. ...</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/29/61</i>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/1/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Farrest Oak</i>		23d. LOCATION (City, town or county) <i>Gaithersburg</i>		23e. (State) <i>Md.</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Constance C. Filton</i>						ADDRESS <i>Barnesville Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 5 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Hill", "Hill", "Hill", "Hill" are visible.]

1
FOR STATE
HEALTH REP.

TO DEFEND MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5802
Item 6 Film G287 5/19/61 jwk 65789

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester
c. LENGTH OF STAY IN lb D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE md b. COUNTY montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 14140 Wheat Oak Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Charles Edward Heidenreich
First Middle Last
4. DATE OF DEATH may 13 1961
Month Day Year

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 1904 9. AGE (In years last birthday) 57 yrs. 10. UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) Vice Pres 10b. KIND OF BUSINESS OR INDUSTRY Inter Scientific co 11. BIRTHPLACE (State or foreign country) Pa 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Wm Heidenreich 14. MOTHER'S MAIDEN NAME Eve Speiler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 167-05-5172 17. INFORMANT Joseph Heidenreich - (wife) Address Item 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (b) sudden
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart attacks

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Bruschant M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 5-13-61

EXAMINER'S NAME (Type) FRANK J. BRUSCHANT Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF May 16, 1961 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 22d. LOCATION (City, town, or country) (State) Montgomery County Maryland

23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Avenue Raymond A. Ziska Silver Spring, Maryland

24a. REC'D BY REGISTRAR MAY 17 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kiser

100-2111
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1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Usual residence: [illegible]
7. Date of death: [illegible]
8. Place of death: [illegible]
9. Cause of death: [illegible]
10. Manner of death: [illegible]

11. Signature of medical examiner: [illegible]
12. Date of examination: [illegible]
13. Signature of coroner: [illegible]
14. Date of certification: [illegible]

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

5803

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

057911

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood, R.F.D. #1				c. LENGTH OF STAY IN 1b 7 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Nursing Home				d. STREET ADDRESS Highland, Md			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Franklin Middle Holland Last Holland				4. DATE OF DEATH Month May Day 10 Year 19 61			
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1899	
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grafton Holland				14. MOTHER'S MAIDEN NAME Elizebeth White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Laura Wilson Highland, Md (Sister)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO C.V.A. Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH years.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to 5/19 19 61 , that (I) (we) last saw the deceased alive on 5/18 19 61 , and that death occurred at 4:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Luciano I. Leal				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Luciano I. Leal				22d. ADDRESS Gaithersburg Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/61		23c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel Cem		23d. LOCATION (City, town, or county) (State) Highland, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE MAY 29 '61	
						25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

Heart Failure
G. V. A.
Hypertension

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with indurated

10. 2/12
Circulation 1.5

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5804

05791

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 4003 Hampden St	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4004 Hampden St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Howard		First Middle Last Howard Hopkins		4. DATE OF DEATH May 23		Day Year 19 61	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1900		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY MA		11. BIRTHPLACE (State or foreign country) MA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Carrie Hopkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Rose Nickens, 4003 Hampden St., Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous heart disease						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/23/61 Address (Street, city, town, or county)							
ACTUAL SIGNATURE Frank J. Broschart		M.D. NAME (Type) Frank J. Broschart					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5 5/27/61		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,		22d. LOCATION (City, town, or country) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR Robert L. Surod				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JUN 7 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

M

1

Montgomery

Washington

6000 Washington St

Howard

col. 1000

laborer

Unknown

Coronary Artery

History of previous heart disease

Frank J. Brown

6/27/51

San Antonio

San Antonio, TX

San Antonio, TX

6/27/51

X

X

X

USA

6000 Washington St

May 22

Logans

6000 Washington St

Washington

Maryland

Montgomery

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5805

05793

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 30			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4626 Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Gregory Last Hutton				4. DATE OF DEATH Month May Day 9 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1899	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Analyst		10b. KIND OF BUSINESS OR INDUSTRY Social Security		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Hutton				14. MOTHER'S MAIDEN NAME Isabella M. Wall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Acute myocardial infarction DUE TO (c) Hypertensive & Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 4 hours days 15 + years	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that at (this hospital) attended the deceased from May 9, 1961 to May 9, 1961 , that it (we) last saw the deceased alive on May 9, 1961 and that death occurred at 6:10AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Harry R. Keiser</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 5/9/61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Harry R. Keiser, M.D.				22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5-10-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAY 11 '61	
				25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CENTRAL OFFICE OF DEATH

(M)

(I)

Investigation 5-19-61, Central Hill, New York
Robert A. Gurnea, Jr., Rochester, N.Y.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 11, MARYLAND

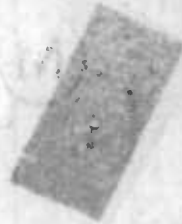
CERTIFICATE OF DEATH

Item 100 Film 4-200 5/9/61.cac

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05794

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 68 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whippany 67X-3	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Joseph Izykowiec		4. DATE OF DEATH Month Day Year May 2, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1926
9. AGE (In years last birthday) 35		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY New Jersey	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Izykowiec		14. MOTHER'S MAIDEN NAME Anna Sharry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Open heart surgery with total replacement of aortic valve DUE TO Aortic valvular insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) E DUE TO Subacute bacterial endocarditis and Rheumatic heart disease (c) Heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4-5 months 20 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 23, 19 61 to May 2, 19 61 , that (I) (we) last saw the deceased alive on May 2, 19 61 , and that death occurred at 2:00 PM from the causes and on the date stated above.			
22a. SIGNATURE James L. Talbert		22b. DATE SIGNED 5-2-61	
22c. PHYSICIAN'S NAME (Type) James L. Talbert M.D.		22d. ADDRESS The Clinical Center National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 5/3/61		23b. DATE THEREOF 5/3/61	
23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town, or county) (State) Whippany, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25. REC'D BY REGISTRAR Bethesda, Maryland	
25a. DATE MAY 4 '61		25b. REGISTRAR'S SIGNATURE Carlton L. Hines	



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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>1</div> <div>5807</div> </div> <div> <div>MONTGOMERY</div> <div>5795</div> </div> </div> <div> <div> <div>1</div> <div>5807</div> </div> <div> <div>MONTGOMERY</div> <div>5795</div> </div> </div>															
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>205 Dogwood Ave</u> d. STREET ADDRESS <u>Takoma Park</u>										
3. NAME OF DECEASED (Type or print) <u>Novella Celestia James</u>					4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1961</u>										
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-79</u>		9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>George W. Rison</u>					14. MOTHER'S MAIDEN NAME <u>Alice M. Mattingly</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Mrs Alice M Reamy</u> Address <u>Same Address</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed in bath room at home</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. TIME OF INJURY Month, Day, Year Hour <u>_____</u> e.m. <u>_____</u> p.m. <u>_____</u> 19 <u>61</u>										20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20d. (City or town) (County) (State) <u>_____</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-30-61</u>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>					Address (Street, city, town, or county) <u>2901 14th St. N.W.</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/1/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>					
23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>										24a. REC'D BY REGISTRAR <u>JUN 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			

FOR NAME
JAMES D. W.

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(M)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5808

05796

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Chevy Chase 15</u> d. STREET ADDRESS <u>1 7104 Beechwood Drive</u> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nona T JARVIS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>19 61</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/17/83</u> 9. AGE (last birthday) <u>78</u> yrs. 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (County & State, or foreign country) <u>Waterville, Ireland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A 50 yrs.</u>		13. FATHER'S NAME <u>John Oulihan</u> 14. MOTHER'S MAIDEN NAME <u>Joanna Foley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>W.F. Jarvis (son) Bloomfield Hills, Mich</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pulmonary Tuberculosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5</u> , 19 <u>61</u> , to <u>May 15</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 14</u> , 19 <u>61</u> , and that death occurred at <u>6:20</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>J. R. Raedy</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5-15-61</u>		22c. PHYSICIAN'S NAME (Type) <u>J. R. Raedy</u> 22d. ADDRESS <u>3701 Leland ST Chevy Chase Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6-17-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> 23d. LOCATION (City, town or county) <u>Washington, D. C.</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u> 25a. REC'D BY REGISTRAR <u>DATE MAY 19 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2882

ARTICLE OF DEATH

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Wm. Sandwood

Wm. Sandwood

Wm. Sandwood (son) Wm. Sandwood

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Wm

Washington, D. C.

Mr. Oliver Cemetery

6-17-01

Butler

Bedside, Md.

ROBERT A. WUMPHREY

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05797

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY FAIRFAX ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 8 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church		d. STREET ADDRESS 906 Crutchfield Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha N. Middle Johnson Last				4. DATE OF DEATH Month May Day 11 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1877	
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Sweden	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown Anderson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Carl F. Johnson				Address 906 Crutchfield Street Falls Church, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobar Pneumonia, Left DUE TO (c) Hemiparesis, left INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 19 61 , to May 11 , 19 61 , that (I) (we) last saw the deceased alive on May 11 , 19 61 , and that death occurred at 9 AM , from the causes and on the date stated above.							
22a. SIGNATURE Robert T. Thibadeau				22b. DATE SIGNED May 11-61		22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.	
22d. ADDRESS 10609 Concord Street Kensington, Md.							
23a. BURIAL, CREMATION, REMOVAL, ETC. Transit-burial		23b. DATE THEREOF 5/12/61-5/14/61		23c. NAME OF CEMETERY OR CREMATORY Pittsfield Cemetery		23d. LOCATION (City, town, or county) (State) Pittsfield, Massachusetts	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. 8434 Georgia Avenue Raymond A. Zick				25a. REC'D BY REGISTRAR MAY 15 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

2809

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St. John's Church

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05798

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 SILVER SPRING</u> d. STREET ADDRESS <u>2102 HILDAOSE DRIVE</u>			
3. NAME OF DECEASED (Type or print) <u>HARRY ALBERT JOHNSON</u>		4. DATE OF DEATH <u>APR 1 1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5, 1890</u>	9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Claim Adjuster</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sh. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>HENRY C JOHNSON</u>			14. MOTHER'S MAIDEN NAME <u>VIRGINIA CORR</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>KATHERINE F JOHNSON</u>			
				Address <u>2102 Hildaose Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Bronchogenic carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Longestive heart failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 months</u>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <u>August 1957</u> to <u>May 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 1, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel T. Kendrick</u>		22b. DATE SIGNED <u>May 1, 1961</u>	22c. PHYSICIAN'S NAME (Type) _____				
22d. ADDRESS <u>927 Penning Drive, Silver Spring, Md.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-4-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeths Church</u>		23d. LOCATION (City, town or county) <u>Lanier Va</u> (State) _____		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Funeral Home</u>		ADDRESS <u>4812 Ga an Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 5 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>		

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5811

Items 7 & 12 fill in 6266 5/8/61 ink

05799

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>1830 R. St.</u> COUNTY <u>Hw.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Hospital-Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel A. Johnson</u>		4. DATE OF DEATH <u>May 2 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 22 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Johansen</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Astrid J. Highfield</u>		Address <u>Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOTENSION + RESPIRATORY ARREST</u> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UREMIA</u> DUE TO (c) <u>CHRONIC PYELONEPHRITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 MINS.</u> <u>6 MONTHS.</u> <u>12 YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PROSTATIC CARCINOMA; GENERALIZED ARTERIOSCLEROSIS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 14 1956</u> to <u>MAY 2 1961</u> , that (I) (we) last saw the deceased alive on <u>APRIL 30 1961</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph D. Connor</u>		22b. DATE SIGNED <u>May 2, 1961</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>JOSEPH D. CONNOR, M.D.</u>		22d. ADDRESS <u>9420 OLD GEORGETOWN RD BETHESDA MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/3/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>		25a. REC'D BY REGISTRAR <u>MAY 3 '61</u>	
ADDRESS <u>1400 Chapel St. NW Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5812

05800

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10033 Dallas Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Berna E. Johnston</u>		4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 26, 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Harold D. Brockwell</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 yr</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20c. TIME OF INJURY Hour e.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1961</u> to <u>May 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1961</u> , and that death occurred <u>1025 P</u> M, from the causes and on the date stated above.	
22a. SIGNATURE <u>Arthur H. Lewis</u> M.D.		22b. DATE SIGNED <u>May 19, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>ARTHUR H. LEWIS</u>		22d. ADDRESS <u>1714 R I Ave NW Wash, DC</u>		22e. REC'D BY REGISTRAR <u> </u> 22f. REGISTRAR'S SIGNATURE <u>Arthur H. Lewis</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) <u>Montgomery County, Maryland</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Ave, Silver Spring, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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May 26, 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely lined in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5813
65801
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN lb Washington Sanitarium and Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, d. STREET ADDRESS 25 E. Wayne Avenue, Apt. 305 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Jones		4. DATE OF DEATH May 18, Last Month Day Year 19 61		9. AGE (In years last birthday) 3 yrs. IF UNDER 1 YEAR Months Days 3 48		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1961		13. FATHER'S NAME George Chalmers Jones		14. MOTHER'S MAIDEN NAME Molina Ellen Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT father		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension + atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 10620 Georgia Ave., Silver Spring, Md.		20g. (County) Montgomery		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.											
22a. SIGNATURE Herbert J. Jacobs M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 10620 Georgia Ave., Silver Spring, Md.				22b. DATE SIGNED 5-18-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5-18-61		23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital		23d. LOCATION (City, town or county) Takoma Park, Maryland		23e. REC'D BY REGISTRAR Robert Hare, M. D.		23f. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Hare, M. D. Washington Sanitarium and Hospital											

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5814

05892

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day 6 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		d. STREET ADDRESS <u>6425-78 street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles W. Jones</u>				4. DATE OF DEATH Month Day Year <u>May 24 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/4/17</u>	
9. AGE (In years, last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West. Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Samuel L. Jones.</u>				14. MOTHER'S MAIDEN NAME <u>Mary J.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-03-3635</u>		17. INFORMANT Address <u>Mrs. Estelle Jones / Samuel</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/23, 1961</u> to <u>5/24, 61</u> that (I) (we) last saw the deceased alive on <u>5/23, 1961</u> and that death occurred at <u>3:00</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. D. Danish</u>				22b. DATE / SIGNED <u>5/27/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. D. DANISH</u>				22d. ADDRESS <u>927 Pershing Dr. Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Church Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Shephardstown, W. Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 29 '61</u>			
ADDRESS <u>Bethesda, Maryland</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

(I)

Robert A. Humphrey, Maryland
Baptist Church of
Reformed Church (M)
Baptist Church of
Reformed Church (M)
Baptist Church of
Reformed Church (M)

1
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISM
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 9 Film G288 6/14/61 iwk											
06943											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 124 Johnson Dr.						d. STREET ADDRESS 124 Johnson Dr.					
3. NAME OF DECEASED (Type or print) First Mary Middle Jones Last Jones						4. DATE OF DEATH Month May Day 31 Year 1961					
5. SEX female		6. COLOR OR RACE cel.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 20, 1883		9. AGE (In years last birthday) 76/77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Emily Harriday, Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED May 31 1961			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 27, 1961		22c. NAME OF CEMETERY OR CREMATORY Haiti., Rockville, Md.		22d. LOCATION (City, town, or country) (State) Rockville, Md.			
23. FUNERAL DIRECTOR Robert L. Suowda						24b. REGISTRAR'S SIGNATURE Charles L. Hanes					
ADDRESS Rockville, Md.						24a. REC'D BY REGISTRAR DATE JUN 12 '61					

1961

1961

M

None

None

None

None

None

x

124 Johnson Dr.

124 Johnson Dr.

18

May 31

None

None

124 Johnson Dr.

124 Johnson Dr.

124 Johnson Dr.

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May 31 1961

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124 Johnson Dr.

124 Johnson Dr.

124 Johnson Dr.

124 Johnson Dr.

124 Johnson Dr.

124 Johnson Dr.

124 Johnson Dr.

CERTIFICATE OF DEATH

Reg. Dist. No.

05803

5816

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SALEEM SOLOMON KABALAN		4. DATE OF DEATH Month Day Year May 10, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 12, 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor--Sewer & Water		10b. KIND OF BUSINESS OR INDUSTRY Aramoun, Lebanon	
11. BIRTHPLACE (State or foreign country) Naturalized		12. CITIZEN OF WHAT COUNTRY? Naturalized	
13. FATHER'S NAME Solomon H. Kabalan		14. MOTHER'S MAIDEN NAME Muhsny Laytoun	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. 217-10-9773	
17. INFORMANT Mr. Said S. Kabalan, Rocky River 16, Ohio		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion, recurrent DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic congestive failure; diabetes mellitus, mild		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/26/61 , 19 61 , to 5/10/61 , 19 61 , that I last saw the deceased alive on 5/10/61 , 19 61 , and that death occurred at 8:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. F. Meadors, M.D.		ADDRESS (Street, city or town, state) Main Street DATE SIGNED	
PHYSICIAN'S NAME (Type) G. F. Meadors, M.D.		Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15, 1961	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) North Olmsted, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		24a. REC'D BY REGISTRAR MAY 15 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1
2

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2310

CERTIFICATE OF DEATH

Montgomery

Married

Carroll

Married - Mr. Atty

Montgomery General Hospital

H. D. 2

SALES

KANAL

10

Conservator - Power & Water

Armenian, Lebanon

Naturalized

2000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

219-10-273 Mr. David A. Robinson, 1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1
FOR STATE
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05804

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>DE</u> b. COUNTY <u>DE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>1/2 hr.</u>				d. STREET ADDRESS <u>5415 Conn. Ave., N.W.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Lakewood Country Club</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Donald C.</u> Middle <u>Keith</u> Last <u>Keith</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-20-05</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vitro Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vitro Corp</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
13. FATHER'S NAME <u>Lincoln Keith</u>		14. MOTHER'S MAIDEN NAME <u>Cora Cain</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Yes Unknown</u>		17. INFORMANT <u>Alice Keith-sister-3338016th Street, N.W.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>suddenly</u> (c) <u>while playing golf.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Dead</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-16-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 19 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

THE STATE
DEPARTMENT

(M)

(1)

Robert L. Humphrey, Secretary, Maryland, and
William A. Mitchell, Secretary, Maryland, and
William A. Mitchell, Secretary, Maryland, and

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5818 CERTIFICATE OF DEATH 05805											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN 1b 31 years					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban						d. STREET ADDRESS 4211 Bradley Lane					
3. NAME OF DECEASED (Type or print) William Henry Kelley						4. DATE OF DEATH Month May Day 29 Year 1961					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 11/12/74					
9. AGE (in years last birthday) 86 yrs.						10. IF UNDER 1 YEAR: Months 29 Days 19 Hours 61 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Custodian						10b. KIND OF BUSINESS OR INDUSTRY Am. Security Bank					
11. BIRTHPLACE (County & State, or foreign country) S. Coventry, Conn.						12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Patrick Kelley						14. MOTHER'S MAIDEN NAME Mary Brannigan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 579-01-5209A					
17. INFORMANT Mrs. Esther Cantrell (Daughter)						Address Same as above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Perforated Duodenal Ulcer 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21. I certify that (I) (this hospital) attended the deceased from September 74 , 19 55 , to May 29 , 19 61 , that (I) (two) last saw the deceased alive on May 28 , 19 61 , and that death occurred at 7A M, from the causes and on the date stated above.											
22a. SIGNATURE J. Blaine Fitzgerald						22b. ADDRESS 8218 Wisconsin Avenue - Bethesda					
22c. PHYSICIAN'S NAME (Type) J. Blaine Fitzgerald						22d. ADDRESS 8218 Wisconsin Avenue - Bethesda					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial						23b. DATE THEREOF 6/7/61					
23c. NAME OF CEMETERY OR CREMATORY Mount St. Benedict Cemetery						23d. LOCATION (City, town or county) (State) Hartford, Conn.					
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.						25a. REC'D BY REGISTRAR Raymond A. Ziska					
ADDRESS 8434 Georgia Ave. SS Md.						25b. REGISTRAR'S SIGNATURE Carlton S. Hanna					
DATE JUN 6 '61											

(M)

(I)

Reprinted Document 11111

X

1
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF HEALTH
please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
5819											
05806											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>					
c. LENGTH OF STAY IN 1b <u>4 yrs</u>						d. STREET ADDRESS <u>3304 Winnett Rd</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3304 Winnett Rd</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Rodham Woinder Kenner</u>						4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1961</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-1908</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Little Tavern</u>			11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Harry W. Kenner</u>						14. MOTHER'S MAIDEN NAME <u>Ada Crandall</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Betty Kenner (wife)</u> Address <u>Stuen 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>History of previous heart disease</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <u>5-30-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			22b. DATE THEREOF <u>6/1/61</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>		
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						24a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>					
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

2

129

(M)

(1)

Robert A. Langhorne, M.D.,
District of Columbia, D.C.
John H. Langhorne, M.D.,
District of Columbia, D.C.

VR A15 (4)
15M 9/60

(M)

None

Residence (Rural)

Days

Washington

District of Columbia

U. S. Naval Hospital

3100 Connecticut Ave., N.W.

None

COOKS

KINGSTON

MAY

19 01

Canadian

9-25-73

01

None

Maryland

USA

Charles W. COOK

Josephine H. COOK

No

None

(H) (Rural, Kingston, same as above)

(1)

Protestantism open reduction of funds
Protestantism open reduction of funds

x

19 01

MAY 13

4:00 PM

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MAY 13

5-13-01

x

O. B. TOWNSEND, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

W. B. Townsend

1901

Kingston National

Atkinson

Virginia

Joe. Gowler's & Sons Funeral Home, 1150 Pa. Ave. N.W.
Leaside
Kingston National

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5821
CERTIFICATE OF DEATH
65808

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 238 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 11908 Coronada Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Trudy Middle Lynn Last Kruis		4. DATE OF DEATH Month May Day 17 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1951
9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months 3 Days 8	IF UNDER 24 HRS. Hours 11 Min. 38
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Kruis	
14. MOTHER'S MAIDEN NAME Mae Van Zwol		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Pulmonary embolus DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Acute lymphocytic leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		INTERVAL BETWEEN ONSET AND DEATH 4 days 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 21, 1960 to May 17, 1961 , that (I) (we) last saw the deceased alive on May 17, 1961 , and that death occurred at 11 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Jerome B. Block		22b. DATE SIGNED 5/18/61	
22c. PHYSICIAN'S NAME (Print) JEROME B. BLOCK, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 22, 1961	
23c. NAME OF CEMETERY OR CREMATORY Zephyrus Cemetery		23d. LOCATION (City, town, or county) (State) Hudsonville, Mich.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Co. Rindell Md.		25a. REC'D BY REGISTRAR DATE 22 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kruis			

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united states :

Acute lymphocytic leukemia

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20/05/12

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5822		Item 5 Film 4257 5/22/61 mh		05800	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>27 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1616 Douglas Street</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Ola</i> First <i>✓</i> Middle <i>✓</i> Last <i>Pear</i>		4. DATE OF DEATH <i>May 12 1961</i> Month <i>May</i> Day <i>12</i> Year <i>1961</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 10, 1889</i>	9. AGE (in years last birthday) <i>72</i> yrs.	10. UNDER 1 YEAR <input type="checkbox"/> Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (State or foreign country) <i>Montgomery Co.</i>	
13. FATHER'S NAME <i>Clem Paul Martin</i>		14. MOTHER'S MAIDEN NAME <i>Clara Hawkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Evelyn Daphney</i> Address <i>616 Douglas, Rockville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X cerebral accident</i> DUE TO (b) <i>Cerebral Arteriosclerosis & dementia</i> DUE TO (c) <i>6 years</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>6 days</i>					INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Feb-27-1955</i> to <i>May-12-61</i> , that (I) (we) last saw the deceased alive on <i>May-11-1961</i> , and that death occurred at <i>9:20 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>William C. Miller</i>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>	
22d. ADDRESS <i>7 Brooks Ave., Gaithersburg, Md.</i>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REBURY (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/16/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park.,</i>	
23d. LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sward</i> ADDRESS <i>Rockville, Md.</i>			
25a. REC'D BY REGISTRAR <i>MAY 18 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			



(M)

(1)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words are difficult to decipher but appear to include:]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
5823
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05810

1. PLACE OF DEATH a. COUNTY Montg. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg Montg.		c. LENGTH OF STAY IN 1b 21 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		d. STREET ADDRESS 8543	
3. NAME OF DECEASED (Type or print) First Delilah Middle May Last Legg		4. DATE OF DEATH Month May Day 11 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1870
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Hampshire Co., West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel W. Anderson		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Kibler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Asbury Methodist Home Records	
17. INFORMANT Asbury Methodist Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH years years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-20 1960 to 5-11 1961 , that (I) (he) last saw the deceased alive on 5-11 1961 , and that death occurred at 2:00 P M, from the causes and on the date stated above.			
22a. SIGNATURE James W. Egan		22b. DATE SIGNED 5-11-61	
22c. PHYSICIAN'S NAME (Type) James W. Egan		22d. ADDRESS 7720 Wisconsin Ave Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-61	
23c. NAME OF CEMETERY OR CREMATORY Timber Ridge		23d. LOCATION (City, town, or county) (State) (Near) Gore. W.Va	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		25a. REC'D BY REGISTRAR Gaithersburg, Md,	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAY 15 '61	

10810

CERTIFICATE OF DEATH

2222

M

NAME OF DECEASED

DATE

RESIDENCE

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

TIME

PLACE

CAUSE OF DEATH

DATE

TIME

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE OF DEATH

TIME

PLACE

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at the City of New York, this 1st day of January, 1901.



REGISTRAR

DATE

TIME

PLACE

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE

TIME

PLACE

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE

TIME

PLACE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5824

Item 2 Film G287 5/22/61 mb

05811

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY in 1b — d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL HALL (10231-CARROLL PLACE)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON Brooklyn d. STREET ADDRESS 10231 CARROLL PLACE 80 Winthrop St.	
3. NAME OF DECEASED (Type or print) IDA MARIAN LLOYD		4. DATE OF DEATH MAY 10 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 27, 1870
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 90 yrs.
11. BIRTHPLACE (County & State, or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? GREAT BRITAIN	
13. FATHER'S NAME WILLIAM LINNELL		14. MOTHER'S MAIDEN NAME ELIZA GELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT —		Address —	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO (b) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ESSENTIAL HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 14 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JULY 21, 1957 to MAY 10, 1961 , that (I) (we) last saw the deceased alive on MAY 10, 1961 , and that death occurred at P.M. , from the causes and on the date stated above.		
22a. SIGNATURE Henry M. Lowden	22b. DATE SIGNED 5-10-61	
22c. PHYSICIAN'S NAME (Type) HENRY M. LOWDEN	22d. ADDRESS 3296 Norman St. Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-12-1961	23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY
23d. LOCATION (City, town or county) (State) WASHINGTON, D. C.		
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR MAY 12 '61
ADDRESS 1756 - Pa. Ave. N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5825

05812

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JACKSON PARK</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSP.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>8710 PLYMOUTH</u>										
3. NAME OF DECEASED (Type or print) <u>Robert Glenn Lloyd</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1961</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-15</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HIGHWAY INSP., D.C. GOVT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. GOVT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>										
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Lloyd</u>												
14. MOTHER'S MAIDEN NAME <u>Ruth Fotters</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war dates of service) <u>YES WWII ARMY</u>												
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Kathryn Lloyd - as deceased</u>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> </td> <td style="width: 40%;"> DUE TO <u>Inanition</u> </td> <td style="width: 30%;"> INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u> </td> </tr> <tr> <td> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> (b) <u>Abdominal Acites</u> </td> <td> <u>15 months</u> </td> </tr> <tr> <td> (c) <u>Cirrhosis of Liver</u> </td> <td> <u>3 years</u> </td> <td> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u>	DUE TO <u>Inanition</u>	INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <u>Abdominal Acites</u>	<u>15 months</u>	(c) <u>Cirrhosis of Liver</u>	<u>3 years</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u>	DUE TO <u>Inanition</u>	INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <u>Abdominal Acites</u>	<u>15 months</u>												
(c) <u>Cirrhosis of Liver</u>	<u>3 years</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										
20f. (City or town)		(County)		(State)										
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1960, to <u>5-6-</u> , 1961, that (I) (we) last saw the deceased alive on <u>5-6-1961</u> , and that death occurred at <u>5:25</u> A.M., from the causes and on the date stated above.														
22a. SIGNATURE <u>N. C. Shoemaker</u>		22b. DATE SIGNED <u>5/7/61</u>		22c. PHYSICIAN'S NAME (Type) <u>N. C. Shoemaker</u>										
22d. ADDRESS <u>8005 Woodbury Dr. Silver Spring, Md -</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>		23b. DATE THEREOF <u>5/7-5/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery, Arlington Co., Va. via McKee Sport,</u>										
23d. LOCATION (City, town or county) <u>(Pa.) Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 12 '61</u>												
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>SILVER SPRING, MD.</u>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1880

STATE OF CALIF.

1880

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STATE OF CALIF.

1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5826

05813

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>30</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10,033 Renfrew Rd. Silver Spring, Md.</u>		d. STREET ADDRESS <u>10,033 Renfrew Rd. Silver Spring</u> <u>1</u> <u>Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>HELEN</u> Last <u>MANZI</u>		4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/20/14</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mohawk, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. John Bell</u> <u>Springfield, Mass</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Keough</u> <u>New York, N.Y.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>081-03-6973</u>	
17. INFORMANT <u>Mr. A. Robert Manzi</u> <u>10,033 Renfrew Rd. Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC INSUFFICIENCY</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>HEPATIC CIRRHOSIS</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1961</u> <u>61</u> <u>MAY</u> <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>5-15</u> <u>1961</u> , and that death occurred at <u>11:00</u> <u>AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>MAY 23 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard A. Fitzgerald</u>		22d. ADDRESS <u>217 UNIVERSITY BLVD E. S.S. McE.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 5/21/61</u>		23b. DATE THEREOF <u>5/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Onondaga County Syracuse N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey Inc.</u> <u>8434 Georgia Ave., Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

80

NAME: **MARK HENRY MARSH**
AGE: **10** YEARS
SEX: **MALE**
DATE OF BIRTH: **1903**
PLACE OF BIRTH: **NEW BEDFORD, MASS.**
RESIDENCE: **NEW BEDFORD, MASS.**
OCCUPATION: **None**
CAUSE OF DEATH: **Heart Disease**
DATE OF DEATH: **1913**
PLACE OF DEATH: **New Bedford, Mass.**

Hebert Insurance
Company

Witness to Sign
1913
212 Commercial Street, N. B.
NEW BEDFORD, MASS.

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5827 65814											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>						c. LENGTH OF STAY IN 1b <u>55 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sanitarium & Hospital</u>						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					
f. STREET ADDRESS <u>9628 Old Spring Rd</u>						g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>COLE</u> Last <u>Marsteller</u>						4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-29-02</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George R. Cole</u>						14. MOTHER'S MAIDEN NAME <u>Minnie Dorsey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>chart - Wash. San.</u>					
17. INFORMANT <u>chart - Wash. San.</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast & Metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleural Empyema</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-7</u> , 19 <u>61</u> , to <u>5-24</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> , 19 <u>61</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>James W. Egan</u> M.D.						22b. DATE SIGNED <u>5/24/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>James W. Egan</u>						22d. ADDRESS <u>7720 Wisconsin Ave. - Bethesda Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>DATE MAY 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

M

5828

CERTIFICATE OF DEATH

Reg. Dist. No.

05815

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3201 Pickwick Lane		d. STREET ADDRESS 3201 Pickwick Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugene J. Middle Matchett Last		4. DATE OF DEATH Month May Day 3 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/99
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative officer Dept. of Justice		11. BIRTHPLACE (State or foreign country) Wash. D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas L. Matchett		14. MOTHER'S MAIDEN NAME Harriet E. Ramler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Eugene J. Matchett, Jr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (metastatic) Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15 , 19 59 , to May 3 , 19 61 , that I last saw the deceased alive on May 3 , 19 61 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur H. Lewis M.D.		ADDRESS (Street, city or town, state) 1714 R I Ave NW	
DATE SIGNED 5/3/61			
PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS		Washington DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/6/61	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE AY 8 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-11-11
10-11-11

(M)

Major General

For Major General

Warrant Officer

was in the hospital for a long time

and was in the hospital for a long time

and was in the hospital for a long time

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5835

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

5831
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05818

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 25 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oscar Middle Paul Last McKay				4. DATE OF DEATH Month May Day 20 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1891	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) Nurseryman		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William McKay				14. MOTHER'S MAIDEN NAME Elizabeth Lang			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW #1				16. SOCIAL SECURITY NO. 214-03-9362		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1954 to May 20 1961 , that (I) (we) last saw the deceased alive on May 20 1961 , and that death occurred at 2:45 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Alfred D. Bonifant				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/20/61	
22c. PHYSICIAN'S NAME (Type) Alfred D. Bonifant, MD				22d. ADDRESS Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/61		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City, town, or county) (State) Montgomery County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR MAY 26 '61	
25b. REGISTRAR'S SIGNATURE Raymond A. Ziska				ADDRESS Silver Spring, Maryland		25c. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

1931

John Doe

123456

123456

23rd

23rd

Continental General Hosp.

123456

Color

Color

Color

Color

March 1, 1931

White

Married

Married

Married

123456

123456

123456

123456

Alfred D. Remond, M.D.

Alfred D. Remond, M.D.

Alfred D. Remond, M.D. 123456

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 814 E. Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elnora Marie MC LAUGHLIN		4. DATE OF DEATH Month Day Year May 12 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 June 1883
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Asbury		14. MOTHER'S MAIDEN NAME Hoffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James Edward MC LAUGHLIN		Address Same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Pulmonary edema 420 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) 19 61
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 May 19 61 to 12 May 19 61 that no (we) last saw the deceased alive on 12 May 19 61 , and that death occurred at 11 AM from the causes and on the date stated above.			
22a. SIGNATURE J.M. YOUNG LT MC USN		22b. DATE SIGNED 17 May 19 61	
22c. PHYSICIAN'S NAME (Type) J.M. YOUNG LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-16-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 17 '61	

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The Federal Home Loan Bank Board
Washington, D.C.

may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5833
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05820

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>34 Yrs</u>				d. STREET ADDRESS <u>11409 Maple View Dr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11409 Maple View Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Naomi</u> Last <u>McNall</u>				4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 25 1894</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Daniel Cunningham</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Dick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr William F McNall, Sr same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1959</u> to <u>May 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 7 1961</u> , and that death occurred at <u>1215 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John Lawrence Avery</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>John Lawrence AVERY</u>				22d. ADDRESS <u>10110 Georgia Ave., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>XXXXX</u>		<u>5/11/61</u>		<u>Parklawn</u>		<u>Rockville, Montgomery, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5834

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN b. 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LEASH SAN.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 4106 Harvard St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Abraham First Meltzer Last
4. DATE OF DEATH 5-27-1961 Month 5 Day 27 Year 1961

5. SEX Male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 10-23-94 Yrs. 66
9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer - retired
10b. KIND OF BUSINESS OR INDUSTRY Roumania
11. BIRTHPLACE (County & State, or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Mr. Isaac Meltzer
14. MOTHER'S MAIDEN NAME Clara Gottfried

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) National Guardsman
16. SOCIAL SECURITY NO. 1093-09-5403
17. INFORMANT Son (Jerome J. Meltzer) & old Records Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442X DUE TO Malaria
Conditions, if any, which gave rise to immediate cause (b) Intensified phlebotomy
(a), stating the underlying cause last, DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive and arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1960 to May 27, 1961, that (I) (was) last saw the deceased alive on May 27, 1961, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE Samuel T. Kimbrell M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 17 May 61
22c. PHYSICIAN'S NAME (Type) 927 Peaching Drive, Silver Spring, Md. 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 5/29/1961 23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. C.E.M. 23d. LOCATION (City, town or county) (State) HYATTSVILLE, MD.

24. FUNERAL DIRECTOR'S SIGNATURE Frederick J. ... ADDRESS 4217-9th Rd 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur S. ... DATE MAY 31 '61

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1885

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "received" and "amount" are faintly visible.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5835

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05822

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 39 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3636 - 16th Street, N.W. Apt. A-815			
3. NAME OF DECEASED (Type or print) First Irvin Middle Fletcher Last Meyer				4. DATE OF DEATH Month May Day 21 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 3, 1919	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Actuary, Internal				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Revenue Emanuel M. Meyer				14. MOTHER'S MAIDEN NAME Julia Holzberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pneumonia 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) 7 Months							INTERVAL BETWEEN ONSET AND DEATH 24 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 12, 1961 to May 21, 1961 , that (I) (we) last saw the deceased alive on May 21, 1961 , and that death occurred at 9:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Vincent H. Bono Jr. M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 5-21-61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Vincent H. Bono Jr. M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5-23-1961		23c. NAME OF CEMETERY OR CREMATORY Judo Torobah Cemetery		23d. LOCATION (City, town, or county) (State) Cincinnati, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler & Sons, Inc. 1756 Pa Ave NW				25a. REC'D BY REGISTRAR MAY 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

12710

CERTIFICATE OF DEATH

12710



RECEIVED
FEB 10 1964
U.S. DEPARTMENT OF HEALTH
HUMAN RESOURCES
DIVISION OF VITAL STATISTICS

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
5836 CERTIFICATE OF DEATH 05823																			
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 87 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5615 McKinley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Francis Gerard MILLER					4. DATE OF DEATH May 27 1961														
5. SEX Male					6. COLOR OR RACE Caucasian														
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 2 August 1896														
9. AGE (In years last birthday) 64 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps					10b. KIND OF BUSINESS OR INDUSTRY -----														
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.					12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME Henry J. Miller					14. MOTHER'S MAIDEN NAME Martha Upton														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW II					16. SOCIAL SECURITY NO. -----														
17. INFORMANT (D) Miss Carol Miller					Address same as # 2 above														
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Bronchogenic carcinoma, lung, with metastasis 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 8 mos.																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that (X) (this hospital) attended the deceased from 3-1 , 19 61 to 5-27 , 19 61 , that (X) (we) last saw the deceased alive on 5-27 , 19 61 , and that death occurred 355AM , from the causes and on the date stated above.																			
22a. SIGNATURE F. H. O'Connell M.D.										22b. DATE SIGNED 27 May 1961									
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC USN										22d. ADDRESS S. Naval Hospital, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 5-31-61									
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery										23d. LOCATION (City, town or county) (State) Arlington, Virginia									
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey										25a. REC'D BY REGISTRAR Arthur E. Kraus									
25b. REGISTRAR'S SIGNATURE 155 Wisconsin Avenue Bethesda, Maryland										DATE MAY 31 '61									

M

1

Montgomery

Maryland

Montgomery

Bethesda (Md.)

by date

Bethesda

U.S. Naval Hospital, Bethesda, Maryland

2011 McKinley Street

Francis

General

Miller

May

21

01

Male

Continued

x

2 August 1955

04

U.S. Marine Corps

Washington, D.C.

021

Henry J. Miller

Marine Station

Yes W II

(D) Miss Carol Miller name as 2 above

Bartholomew's, long, with metastasis 8 mos.

x

2-27

01

3-1

01

2-27

01

21 May 1951

F. H. O'Connell, MD, MC USN, Naval Hospital, Bethesda, Maryland

Bethesda

2-27-1

1111 Wisconsin Avenue
Bethesda, Maryland

Washington, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
5837										
05824										
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 519 Beall Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Richard Wagonen First Middle Last					4. DATE OF DEATH May 16 Month Day Year					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-15-04		9. AGE (In years last birthday) 56 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer					10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy			11. BIRTHPLACE (County & State, or foreign country) Illinois		
13. FATHER'S NAME Carl MINDTE					14. MOTHER'S MAIDEN NAME Lola FERN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 553-16-2519		17. INFORMANT (S)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct, posterior septal 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calcific aortic stenosis; rt. upper lobe pneumonia								INTERVAL BETWEEN ONSET AND DEATH hours		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 26 8:50AM to May 16 , 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 16 , 19 61 , and that death occurred at M , from the causes and on the date stated above.										
22a. SIGNATURE Kenneth V. Harshman					22b. DATE SIGNED 5-16-61			22c. PHYSICIAN'S NAME (Type) Kenneth V. HARSHMAN, LT, MC, USN		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5-19-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler					24b. ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR MAY 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

Monetary

Residence (Home)

U. S. Naval Hospital

Richard

Regiment

Kind

May 19

19

Info

Continued

U. S. Navy

Illinois

USA

Call Number

John F. Kennedy

Yes Will-Form 553-10-2519 (a)

Agency specializing in this, position request

Page

California North American; no upper level personnel

x

Richard V. Kennedy

Kenneth V. HARRISON, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Virginia

Arlington

Arlington National

5-19-61

Encl.

Personnel General Home, Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5838

05825

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE South Carolina b. COUNTY Orangeburg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 212 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 416 Ellis Avenue			
3. NAME OF DECEASED (Type or print) Edward				4. DATE OF DEATH Month May 18 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		9. AGE (In years last birthday) yrs. 14		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Lonnie E. MINTZ				14. MOTHER'S MAIDEN NAME Lillie Mae BILLY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Aggranulocytosis Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malabsorption syndrome with ricketts							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 18 1960 to May 18 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 18 1961 , and that death occurred at 3:43AM , from the causes and on the date stated above.							
22a. SIGNATURE G. B. Avery				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-18-61	
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 5-23-61		23c. NAME OF CEMETERY OR CREMATORY Church		23d. LOCATION (City, town or county) (State) Orangeburg So. Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Bacon Funeral Home, 1722 7th St., NW, WashDC				25a. REC'D BY REGISTRAR JUN 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

REGON FEDERAL HOME, TYPE FOR ST. NW, WASHDC

72344
Chen
O. H. WERRY, JR, MC, D. H.

Grandmother
U. S. Naval Hospital, Bethesda, Md.
801 Carolina

18-18-1
MAY 18 1961
MAY 18 1961
MAY 18 1961

None
Hospital Records
MILITARY RECORDS

Negro
South Carolina

MINN
MAY 18 1961
U. S. Naval Hospital

215 days
Orangeburg
South Carolina

(M)

(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5839

06978

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b Washington Sanitarium and Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, d. STREET ADDRESS 8411 Galveston Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Mitchell		4. DATE OF DEATH Month May Day 26 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1961		9. AGE (In years last birthday) 2 yrs. 55 Min.		10. UNDER 1 YEAR Months 2 Days 55		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? America							
13. FATHER'S NAME William Landon Mitchell				14. MOTHER'S MAIDEN NAME Mary Carol Darby				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. no				17. INFORMANT mother			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X Conditions, if any, which gave rise to immediate cause (b) 776X (c), stating the underlying cause last. DUE TO (b) 776X DUE TO (c) 776X												INTERVAL BETWEEN ONSET AND DEATH 2 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Silver Spring, Md (County) Montgomery (State) Md							
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.																			
22a. SIGNATURE H.H. Diamond				M.D. H.H. DIAMOND				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 5-26-61							
22c. PHYSICIAN'S NAME (Type) H.H. DIAMOND				22d. ADDRESS 911 - Silver Spring ave				22e. REC'D BY REGISTRAR JUN 9 '61				22f. REGISTRAR'S SIGNATURE Arthur S. Hume							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 6-8-61				23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital				23d. LOCATION (City, town or county) Takoma Park, Md (State) Md							
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D. Wash. San. & Hospital				24. ADDRESS Washington Sanitarium and Hospital				25a. REC'D BY REGISTRAR JUN 9 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

VR A15 (4)
15M 9/60

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08878

08878



Montgomery

Marland

Montgomery

Silver Spring

Torona Park

5111 Balwinson Road

Hampton Sanatorium and Hospital

May 26, 1941

Mitchell

May 26, 1941

May 26, 1941

White

Male

Montgomery

Marland

Montgomery

Male

Harry

Carol

Harry

Mitchell

Land

William

Robert

no

no

no

U.S. District Court

2-2-41

H.H. Diamond

Hampton Sanatorium and Hospital, Torona Park, Md.

2-2-41

Continuation

Robert A. Bar, Jr., D. Wash., San. & Hospital

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5840

U5826

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>8 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md.</u> f. COUNTY <u>Montgomery</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> h. STREET ADDRESS <u>10510 Greenacres Dr.</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian Ella Moon</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>23</u> - Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-99</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby sitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Due</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Schaefer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMATION <u>Washington Sanitarium Hospital Recd.</u>		Address <u>Germany</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cerebral vascular disease</u> (c) <u>Mild vascular hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs.</u> <u>5-10 yrs.</u> <u>10+ yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>

21. I certify that (I) (this hospital) attended the deceased from March, 1961, to May 23, 1961, that (I) (no) last saw the deceased alive on May 23, 1961, and that death occurred at 8:55 PM, from the causes and on the date stated above.

22a. SIGNATURE <u>J. Frederick Barr</u>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 5-25-61	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>J. Frederick BARR, MD</u>		22d. ADDRESS <u>4500 College Ave, College Park, Md.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>	23b. DATE THEREOF <u>5/28/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hudson Cemetery</u>	23d. LOCATION (City, town or county) <u>Hudson Iowa</u> (State) <u> </u>
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24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>daymond A. Ziska</u>	ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Maryland</u>	25a. REC'D BY REGISTRAR DATE <u>MAY 29 '61</u>	25b. REGISTRAR'S SIGNATURE <u>William L. Hanna</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
5841														
u5827														
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					c. LENGTH OF STAY IN 1b D.O.A.									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital					d. STREET ADDRESS Ashton									
3. NAME OF DECEASED (Type or print) First Middle Last CORDELIA FRANCES MOORE					4. DATE OF DEATH Month Day Year May 27 19 61									
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-1-1887		9. AGE (In years last birthday) 74 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. none					17. INFORMANT 1021 Briggs Chaney Road, Silver Spring, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH sudden				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Frank J. Broschart					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 5-27-61				
EXAMINER'S NAME (Type) Frank J. Broschart					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county) 254 Carroll St. N. H.				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF May 31, 1961		22c. NAME OF CEMETERY OR CREMATORY Rock Hill Cemetery		22d. LOCATION (City, town, or country) Rockville Montg Co - Md.		22e. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				
22f. FUNERAL DIRECTOR Arthur S. Kraus		ADDRESS 254 Carroll St. N. H.		DATE MAY 31 '61										

1055

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

DP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
5842											
CERTIFICATE OF DEATH											
Reg. Dist. No. 05828											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				31	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>606 University Blvd, West</u>						d. STREET ADDRESS <u>606 University Blvd, West</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Teresa</u> Last <u>Moran</u>						4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1905</u>		9. AGE (In years, last birthday) <u>56 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Internal Revenue</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Maurice E. O'Connor</u>						14. MOTHER'S MAIDEN NAME <u>Katie M. Wheatley</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>Informant</u> Mrs. Howard P. Hale, 1833 Avenel Rd. Adelphi, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X Congestive heart failure</u> DUE TO (b) <u>Rheumatic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>30 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 24, 1954</u> to <u>May 30, 1961</u> , that I last saw the deceased alive on <u>May 30, 1961</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Raymond Bradshaw</u>				ADDRESS (Street, city or town, state) <u>345 University Blvd, West</u>				DATE SIGNED <u>5/30/61</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>				ADDRESS <u>Silver Spring, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Prince George's Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond A. Ziska</u>						ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5843 05820											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring						c. LENGTH OF STAY IN lb 13 months					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton Nursing Home						d. STREET ADDRESS 1018 Woodside Parkway					
3. NAME OF DECEASED (Type or print) C First Narolyn Middle Day Last Nau						4. DATE OF DEATH 5-1-61 Month 5 Day 1 Year 1961					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 17-1890		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house-wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME C. Edward Day						14. MOTHER'S MAIDEN NAME Edith V. Laird Deceased					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or date of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mabel Ames		Address 1018 Woodside Pkwy, SS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 5 minutes 10 years	
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (the hospital) attended the deceased from July 1955 to May 1, 1961 , that (I) (we) last saw the deceased alive on April 30, 1961 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.											
22a. SIGNATURE James M. Whitlock M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-1-61			
22c. PHYSICIAN'S NAME (Type) James M. Whitlock						22d. ADDRESS 7717 Carroll Ave, Takoma Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 3, 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Prince George County Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC. Raymond A. Jaska						ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR MAY 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

(M)

(I)

Handwritten text, possibly a signature or name, appearing in the center of the page.

Handwritten text at the bottom of the page, including what appears to be a date "11-30-61" and other illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
5844

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

65831

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle (None) Last Nichols		4. DATE OF DEATH Month May Day 18 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 28, 1913
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Tsoukatos		14. MOTHER'S MAIDEN NAME Constance Kalodimas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO (b) Mixed mesodermal Tumor of Uterus DUE TO (c) lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 11 (this hospital) attended the deceased from April 24 , 19 61 , to May 18 , 19 61 , that 11 (we) last saw the deceased alive on May 18 , 19 61 , and that death occurred at 6:15 A.M. the causes and on the date stated above.			
22a. SIGNATURE Benjamin A Borowsky		22b. DATE SIGNED 5/18/61	
22c. PHYSICIAN'S NAME (Type) BENJAMIN A. BOROWSKY, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 5-18-61		23b. DATE THEREOF 5-18-61	
23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cem.		23d. LOCATION (City, town, or county) (State) Norfolk, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE MAY 23 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

* p < 0.05, ** p < 0.01, *** p < 0.001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
Item 23b Film G288 6/12/61 mh															
5845															
051															
05832															
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN b 39 days				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital			
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				d. STREET ADDRESS 8405 Dixon Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Mark				First Leroy				Middle NOLL				Last May			
4. DATE OF DEATH May				Month 28				Day 19				Year 61			
5. SEX Male				6. COLOR OR RACE Caucasian				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12-25-99			
9. AGE (In years last birthday) 61 yrs.				IF UNDER 1 YEAR Months Days Hours Min.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter				11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? USA															
13. FATHER'S NAME Elmer S. NOLL				14. MOTHER'S MAIDEN NAME Margaret BARTHO											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 7-17-17 to 8-12-19 579-14-5616				17. INFORMANT (W) Mrs. Flora L. Noll, same as #2 above				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) the bronchus DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 mos.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 19 1961 to May 28 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 28 1961 , and that death occurred at 4:10PM , from the causes and on the date stated above.															
22a. SIGNATURE Paul G. Linaweaver, Jr.				M.D. Paul G. LINAWEAVER, JR., LT, MC, USN				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5-29-61			
22c. PHYSICIAN'S NAME (Type) Paul G. LINAWEAVER, JR., LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 1, 1961				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE W. E. Humphrey				ADDRESS 8434 Georgia Ave.				25. RECD BY REGISTRAR JUN 5 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5846

05833

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rensington Gardens SAN.</u>		d. STREET ADDRESS <u>6311 Kirby Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Offenheiser</u>		4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/82</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles J. Offenheiser</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hopper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u> <u>Unknown</u>	
17. INFORMANT <u>William F. Offenheiser-son-same 2d</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE & UREMIA</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 WEEKS</u> <u>8 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1957</u> to <u>MAY 25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5-23</u> , 19 <u>61</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip R. James</u>		22b. DATE SIGNED <u>5/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ph. Philip R. James</u>		22d. ADDRESS <u>WASHINGTON CLINIC, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 5/27/61</u>		23b. DATE THEREOF <u>5/27/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>South Church Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bergenfield, New Jersey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24b. ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>MAY 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

65834

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN lb <u>18 days</u>		d. STREET ADDRESS <u>4512 Leland St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE</u> First <u>Delmer</u> Middle <u>a</u> Last <u>Phipps</u>		4. DATE OF DEATH <u>May 20</u> 19 <u>61</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (1880) <u>7/24/80</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AWF</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK B. CORE</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE Wilhelm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (Son) <u>Lester Phipps</u>		Address <u>Bethesda 4512 Leland St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peripheral venous thrombosis</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral infarction, cerebral thrombosis, left middle cerebral artery</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2 May</u> , 19 <u>61</u> , to <u>5/20</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>20 May</u> , 19 <u>61</u> , and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John G. Boll</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John G. Boll</u>		22d. ADDRESS <u>7936 Old Georgetown Rd, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Freeland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Kortenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAY 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>		25c. DATE	

(M)

(T)

Frank & Gore

No

Caroline Wilhelm
Lester Topp
Marjand

John C. Bell
5-24-61 Middlebury, Vt.
Lester Topp

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8 & 9 Film G28705835

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3824 Denfeld Street Ave,		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 3824 Denfeld Street Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT SLADE PLOWMAN		4. DATE OF DEATH Month Day Year May 4, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 Apr. 11, 1883
9. AGE (In years, months, days) 77 yrs. 0 mo. 23 days		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Siderographer - Retired		11. BIRTHPLACE (County & State, or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Samuel James Plowman	
14. MOTHER'S MAIDEN NAME Isabel Perine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. Adelaide Cobb Plowman		17. INFORMANT Wife Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Heart Failure 502.0 DUE TO (b) Emphysema - chronic bronchitis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from March 5-4, 1961 , to 5-4, 1961 , that (I) (we) last saw the deceased alive on 5-4, 1961 , and that death occurred at 7 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Alfred S. Norton M.D.		22b. DATE May 5, 1961	
22c. PHYSICIAN'S NAME (Type) ALFRED S. NORTON		22d. ADDRESS 4711 Highland Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	23b. DATE THEREOF 5/9/61	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. via Burr Davis Fun. Home, Mt. Vernon, N.Y.	23d. LOCATION (City, town or county) (State) New York City, N. Y.
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR MAY 9 '61	
25b. REGISTRAR'S SIGNATURE Robert A. Norton			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1983

Unemployment

Registration

3824 Bedford Street Ave.

Registration

3824 Bedford Street Ave.

ROBERT STARS

STOWMAN

of

Male White

Aug. 11, 1922

Stenographer - Retired

New York

U. S.

Samuel James Plowman

Issued Permit

Name as Item 2.

Adelaide Condo Plowman

No

(I)

ALFRED S. KORTON

4711 Highland Ave., Bethesda, Md.

Partial-Immigrant

Woodlawn Cem., Virginia
Davis, Virginia, N.Y.

ROBERT A. PUMPHREY

Bethesda, Md.

New York City, N.Y.

11

Beckwith (Herald)

U. S. Naval Hospital

John

Male

U. S. Marine Corps

1

Unknown

1956 to 1958

176-32-0535

(M) Mrs. Cleveland Wilson, 176 Mayflower St.

3 mos.

Cleveland Wilson

Pennsylvania

USA

01 days

Missouri

307 31st St

PEPPER

Allen

82

2-10-59

X

01

22

100

0225

0225

Pennsylvania

Missouri

Beckwith (Herald)

U. S. Naval Hospital

176-32-0535

Cleveland Wilson

USA

May 59

March 59

May 59

01

X

2-25-61

X

Robert T. Brooks, Jr., 176 Mayflower St., 176 Mayflower St., Beckwith, MI.

22

176 Mayflower St.

176 Mayflower St.

176 Mayflower St.

176 Mayflower St.

176 Mayflower St.

176 Mayflower St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5850

05857

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS 1135 Loxsford Terrace	
3. NAME OF DECEASED (Type or print) Thelma Elizabeth Pyle		4. DATE OF DEATH May 11 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1907
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur M. Anderson		14. MOTHER'S MAIDEN NAME Uda G. Remington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --66--	
17. INFORMANT Wm. H. Pyle		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } Carcinomatosis Carcinoma of colon DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 4 mos. 11 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 5/1961 to 5/11/61 , that (I) (we) last saw the deceased alive on 5/9/1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Donald Nelson M.D.		22b. ADDRESS 1020 Georgia Ave Silver Spring, Md.	
22c. PHYSICIAN'S NAME (Type) Donald Nelson		22d. DATE 5/11/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/15/61	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City, town or county) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE MAY 18 '61	
ADDRESS 4739 Balt. Ave. Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

(M)

silver bar

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5851

05838

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 40 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS Box 1236 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Deborah Middle Lynn Last Randall				4. DATE OF DEATH Month May Day 23 Year 19 61											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1958		9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David E. Randall, Jr.						14. MOTHER'S MAIDEN NAME Margaret Thomas									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 587.3 IMMEDIATE CAUSE (a) Atelectasis Right Medial Lobe and Left Upper Lobe and extensive Pneumonitis. DUE TO Cystic Fibrosis of the Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diffuse Emphysema; Respiratory acidosis DUE TO (c) Diffuse Emphysema; Respiratory acidosis														INTERVAL BETWEEN ONSET AND DEATH 2-3 Weeks 3 Years 1-2 Yrs; 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 13, 1961 , to May 23, 1961 , that (I) (we) last saw the deceased alive on May 23, 1961 , and that death occurred at 12:15am , from the causes and on the date stated above.															
22a. SIGNATURE HUGH E. EVANS, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-23-61							
22c. PHYSICIAN'S NAME (Type) HUGH E. EVANS, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 25-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill				23d. LOCATION (City, town or county) (State) Lutland Md					
24. FUNERAL DIRECTOR'S SIGNATURE Samuel Bros.						ADDRESS 1661- Good Hope Rd SE WASH 20		25a. REC'D BY REGISTRAR DATE MAY 24 '61		25b. REGISTRAR'S SIGNATURE Charles S. Evans					

CENTRAL AND DEATH

M

1

1. Name of the deceased
2. Date of death
3. Place of death
4. Cause of death
5. Age at death
6. Sex
7. Race
8. Religion
9. Marital status
10. Occupation
11. Education
12. Social status
13. Family history
14. Medical history
15. Mental history
16. Physical examination
17. Laboratory examination
18. Pathological examination
19. Toxicological examination
20. Forensic examination

21. Autopsy
22. Post-mortem examination
23. Identification
24. Burial
25. Cremation
26. Dissection
27. Examination of the body
28. Examination of the organs
29. Examination of the tissues
30. Examination of the cells
31. Examination of the molecules
32. Examination of the atoms
33. Examination of the subatomic particles
34. Examination of the elementary particles
35. Examination of the fundamental particles
36. Examination of the constituents of matter
37. Examination of the constituents of energy
38. Examination of the constituents of the universe
39. Examination of the constituents of life
40. Examination of the constituents of death

41. Examination of the constituents of the human body
42. Examination of the constituents of the human mind
43. Examination of the constituents of the human soul
44. Examination of the constituents of the human spirit
45. Examination of the constituents of the human heart
46. Examination of the constituents of the human brain
47. Examination of the constituents of the human liver
48. Examination of the constituents of the human lungs
49. Examination of the constituents of the human stomach
50. Examination of the constituents of the human intestines
51. Examination of the constituents of the human kidneys
52. Examination of the constituents of the human bladder
53. Examination of the constituents of the human uterus
54. Examination of the constituents of the human vagina
55. Examination of the constituents of the human penis
56. Examination of the constituents of the human testis
57. Examination of the constituents of the human prostate
58. Examination of the constituents of the human rectum
59. Examination of the constituents of the human anus
60. Examination of the constituents of the human mouth
61. Examination of the constituents of the human nose
62. Examination of the constituents of the human ears
63. Examination of the constituents of the human eyes
64. Examination of the constituents of the human skin
65. Examination of the constituents of the human hair
66. Examination of the constituents of the human nails
67. Examination of the constituents of the human teeth
68. Examination of the constituents of the human tongue
69. Examination of the constituents of the human throat
70. Examination of the constituents of the human larynx
71. Examination of the constituents of the human trachea
72. Examination of the constituents of the human bronchi
73. Examination of the constituents of the human lungs
74. Examination of the constituents of the human heart
75. Examination of the constituents of the human blood
76. Examination of the constituents of the human lymph
77. Examination of the constituents of the human sweat
78. Examination of the constituents of the human tears
79. Examination of the constituents of the human saliva
80. Examination of the constituents of the human urine
81. Examination of the constituents of the human feces
82. Examination of the constituents of the human vomit
83. Examination of the constituents of the human sweat
84. Examination of the constituents of the human tears
85. Examination of the constituents of the human saliva
86. Examination of the constituents of the human urine
87. Examination of the constituents of the human feces
88. Examination of the constituents of the human vomit
89. Examination of the constituents of the human sweat
90. Examination of the constituents of the human tears

5852
MARYLAND STATE DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05839

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS TRIDELPHIA ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EFFIE Middle LAVERNA Last REED				4. DATE OF DEATH Month MAY 21 Day 21 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/24/06	
9. AGE (In years lost birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.		IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TENN.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME DAVID COOK				14. MOTHER'S MAIDEN NAME GERTIE FRAZIER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATIC ENDOCARDITIS (MITRAL STENOSIS) DUE TO (c) RHEUMATIC ENDOCARDITIS (MITRAL STENOSIS)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATIC ENDOCARDITIS (MITRAL STENOSIS)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3/27/1961 to MAY 21, 1961 that (I) (we) last saw the deceased alive on MAY 20, 1961 , and that death occurred at A M, from the causes and on the date stated above.							
22a. SIGNATURE Charles S. Whitaker				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/22/61	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.				22d. ADDRESS CLARKSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 23, 1961		23c. NAME OF CEMETERY OR CREMATORY Sharon Baptist		23d. LOCATION (City, town, or county) (State) West Friendship, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Oliver L. McPherson				ADDRESS Damascus, Md.		25a. REC'D BY REGISTRAR DATE MAY 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Howard							

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13X-2

CERTIFICATE OF DEATH

STATE OF TEXAS

COUNTY OF DALLAS

DATE

DECEASED

LAST NAME

FIRST NAME

AGE

SEX

RACE

RELIGION

CAUSE OF DEATH

PLACE OF DEATH

XXXXXXXXXXXXXXXXXXXX

DECEASED'S RESIDENCE (If different from place of death)

DATE

DECEASED

BY

John J. Smith

CLERK OF COURT

NOTARY PUBLIC

Notary Public for the State of Texas

My Commission Expires

DALLAS, TEXAS

DATE

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>		d. STREET ADDRESS <i>4219 Roundhill Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Virginia Alice Reedy</i>		4. DATE OF DEATH Month Day Year <i>May 10 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 10 1877</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours <i>11 0</i>	11. IF UNDER 24 HRS. Min. <i>0</i>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Nursing Home Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombus</i> DUE TO <i>Generalized Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>232X</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>4 days 20 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1954</i> to <i>10 May 1961</i> , that (I) (we) last saw the deceased alive on <i>1961</i> , and that death occurred at <i>10 May 1961</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Wm. S. Murphy</i>		22b. DATE SIGNED <i>10 May 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Wm. S. Murphy</i>		22d. ADDRESS <i>615 W. Montg. Ave. Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/13/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Pleasant View Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Mt. Jackson, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>MAY 15 '61</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 14 Film G287 5/17/61 mh											
5854 05841											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <u>3891-Porter St. NW.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Ethel M. Reese</u>						4. DATE OF DEATH <u>May 8 1961</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11/19/07</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exec. Secretary Dept. of State</u>						10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Middletown Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>											
13. FATHER'S NAME <u>John W Besswer</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>5-054</u>					
17. INFORMANT <u>(SON) John Reese</u>						Address <u>Rancho Lane Toledo Ohio</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>											
DUE TO (b) <u>Myocarditis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>May 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:25</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>De Witt E. DeLawter</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5/8/61</u>											
22c. PHYSICIAN'S NAME (Type) <u>DEWITT E. DELAWTER</u> 22d. ADDRESS <u>8025 ABERDEEN Rd. Bethesda 14, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 5-9-61</u>											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY <u>Woodside Cemetery</u>											
23d. LOCATION (City, town or county) (State) <u>Middletown, Ohio</u>											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ROBERT A. PUMPHREY Bethesda, Md.</u>											
25a. REC'D BY REGISTRAR DATE <u>MAY 11 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

(M)

(I)

ROBERT A. PUMPHREY
Bethesda, Md.
Middlebrook, Ohio
3-2-51
3-2-51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5855

Items 8, 9 & 12 Film 6287 5/21/61

05842

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b Rockville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1302 Abbot Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1302 Abbot Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walla First Middle Last Rehnberg 4. DATE OF DEATH Month Day Year May 10 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1899 9. AGE (In years last birthday) 71 IF UNDER 1 YEAR: Months Days Hours Min. 7 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State, or foreign country) Sweden 12. CITIZEN OF WHAT COUNTRY? Sweden ✓		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 127-14-1333 17. INFORMANT Gloria Fleming-Daughter-Same 2d Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO RENAL FAILURE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. CARCINOMA OF GALLBLADDER PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED METASTASIS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from MARCH 21, 1961 to MAY 11, 1961 , that (I) (we) last saw the deceased alive on MAY 10, 1961 , and that death occurred on MAY 11, 1961 , from the causes and on the date stated above.	
22a. SIGNATURE Gordon S. Rosenberger 22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger 22b. DATE SIGNED MAY 10, 1961 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 310 W. Montg. Ave, Rockville, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 5/15/61 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR MAY 15 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Montgomery

Rockville

1302 Abbott Road

Wells

Female White

Howeville

Unknown

no

x

Rehberg

Rockville

Maryland

1302 Abbott Road

May

Sept. 29, 1939, 71

Sweden

Unknown

127-14-1333 Office Elevator-Dugout-Same 24

Henry F. Rupp

Henry F. Rupp

Carroll at Washington

General at Washington

Robert A. Rosenberg

Robert A. Rosenberg, Bethesda, Maryland MAY 1
Creation 5/15/61 Cedar Hill Observatory
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN lb <u>16 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANGLEY PARK</u>				d. STREET ADDRESS <u>7914 14th St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
									4. DATE OF DEATH <u>MAY 9 1961</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 8, 1961</u>		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	
										IF UNDER 24 HRS. Hours Min. <u>16 30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>			
13. FATHER'S NAME <u>Stephen Sidney Reid</u>						14. MOTHER'S MAIDEN NAME <u>MARILYN JANET WHITMORE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Stephen Reid</u>				Address <u>7914 14th St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS</u> <u>782.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>PREMATURITY</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>16 1/2 hrs.</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>5-8, 1961</u> to <u>5-9, 1961</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>MARY K. L. Sartwell,</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-9-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Mary K.L. Sartwell, M. D. 6811 Riggs Rd., Hyattsville, Maryland</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5-9-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Washington Sanitarium and Hosp.</u>				ADDRESS				25a. REC'D BY REGISTRAR <u>MAY 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

2075237843

(M)

(I)

Robert A. Laro, Jr., Washington, D.C.

Washington, D.C. 20540

Very truly yours,

Enclosure

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5857

65844

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>4 days</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11600 Orebaugh Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY IRVING REININGA</u>		4. DATE OF DEATH <u>May 9 1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-1842</u> yrs.		9. AGE (in years last birthday) <u>9</u> Months <u>9</u> Days <u>19</u> Hours <u>61</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>HARRY REININGA</u>		14. MOTHER'S MAIDEN NAME <u>Jane James</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Army W.W.2</u>		16. SOCIAL SECURITY NO. <u>351-45-7180</u>		17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Branchogenic Coronavirus</u>		DUE TO (b) <u>162.1</u> DUE TO (c) <u>162.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 8</u> , 19 <u>61</u> , and that death occurred <u>3:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George William Ware</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George William Ware</u>				22d. ADDRESS <u>1835 Eye St NW.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>5/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate Of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Montgomery Co. Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Ave, Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 15 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

VR A15 (4)
15M 9/60

200

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5858

05845

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 39 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Berkley Springs c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkley Springs d. STREET ADDRESS 85X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Harold Alston RICE			4. DATE OF DEATH Month May Day 25 Year 1961		
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-29-94		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Educational Adviser			10b. KIND OF BUSINESS OR INDUSTRY ICA		
11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frank RICE			14. MOTHER'S MAIDEN NAME Bertha FISHER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WWI		
17. INFORMANT (W) Mrs. Eleanor Rice, same as #2 above			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aneurysm (ascending aorta) with rupture into left lung Etiology undetermined (One day postoperative) DUE TO (b) left lung DUE TO (c) Etiology undetermined (One day postoperative) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 16, 1961 , to May 25, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 25, 1961 , and that death occurred at 10A , from the causes and on the date stated above.					
22a. SIGNATURE James E. Mc Clenathan M.D. 22b. DATE SIGNED 5-25-61					
22c. PHYSICIAN'S NAME (Type) James E. MC CLENATHAN, CDR, MSC, USN					
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-61		23c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery	
23d. LOCATION (City, town or county) Berkley Springs		23e. (State) W. Va.		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS Bethesda, Md.					
25a. REC'D BY REGISTRAR MAY 29 '61					
25b. REGISTRAR'S SIGNATURE Arthur S. Kline					

222

1

Montgomery

West Virginia

Rechenada (Rural)

32 days

Rockley Springs

U. S. Naval Hospital

Harold

Alison

Wick

1941

1941

1941

Wife

Occupation

TOA

Exercitonal Advisor

West Virginia

USA

Frank Rice

1

1941

(W) Mrs. Eleanor Rice, same as above

X

April 10 1941

May 22 1941

X

James E. Mc CREATH, CDR, USN, U. S. Naval Hospital, Bethesda, Md.

Berkeley Springs W. Va.

Greenway Cemetery

5-29-41

Harold

R. A. Pamphrey, Funeral Home, Bethesda, Md.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form No. 1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages (and 2 with the State Board of Health) or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

5859

Item 14 Film G287

5/24/61 iwb

05846

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>DoA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>901 Pershing Dr.</u>		d. STREET ADDRESS <u>612 N St., N. W</u>	
3. NAME OF DECEASED (Type or print) <u>Frank Richardson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <u>50</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Timothy Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Mandy unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>M.C. Polie</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Friedlander's Pneumonia</u> <u>491X</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>County Home</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 15 '61</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1
5860
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05847

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS GUY RIORDAN				4. DATE OF DEATH Month Day Year MAY 12, 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-21-1893	
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT				10b. KIND OF BUSINESS OR INDUSTRY GENERAL		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME EDWARD RIORDAN				14. MOTHER'S MAIDEN NAME ANNA BRIGHTWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWI 217 32 1739				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Cranial Hemorrhage 331X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 5-6 19 61 to 5-12 19 61 , that (I) (we) lost saw the deceased alive on 5-11 19 61 , and that death occurred at 2 1/2 M, from the causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-12-61	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.				22d. ADDRESS GAITHERSBURG, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-15-61		23c. NAME OF CEMETERY OR CREMATORY St. Peter's		23d. LOCATION (City, town, or county) (State) Libertytown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 15 '61	
						25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1980



DATE OF DEATH: 1-15-1980
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
BIRTH DATE: [illegible]
BIRTH PLACE: [illegible]
MARRIAGE DATE: [illegible]
MARRIAGE PLACE: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
RELIGION: [illegible]
SIGNED: [illegible]
WITNESSED: [illegible]
REGISTERED: [illegible]

Inter-Coroner's Return

[Faint, mostly illegible text and signatures at the bottom of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05848

5861

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b Five years				d. STREET ADDRESS 170 Glenmont - Colesville Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 170 Glenmont - Colesville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Edgar Robey				4. DATE OF DEATH Month May Day 16 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1872	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 5 Days 9 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Business				10b. KIND OF BUSINESS OR INDUSTRY Wholesale Druggist		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John H. Robey				14. MOTHER'S MAIDEN NAME Alexenia Roby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-07-1328			
17. INFORMATION Miss Lucille C. Robey				Address 170 Glenmont - Colesville Rd., Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary Tract infection DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Amputation Left leg DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 months 2 months 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month May Day 5 Year 1961 Hour 4:00 o. m. PM				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Silver Spring				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from January 1961 , to 5/16/61 , 19____, that I last saw the deceased alive on 5/13/61 , 19____, and that death occurred at 4:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8107 Eastern Avenue Silver Spring, Md. DATE SIGNED May 16, 1961							
ACTUAL SIGNATURE Bernard H. Ostrow				PHYSICIAN'S NAME (Type) Bernard H. Ostrow			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/61		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc				ADDRESS 8434 Georgia Ave Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE MAY 22 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Knead							

TO HOSPITAL: OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5862

05849

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 132 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Virginia b. COUNTY Triangle c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Courtney Drive d. STREET ADDRESS 83x2		
3. NAME OF DECEASED (Type or print) Carl Albert ROHLOFF			4. DATE OF DEATH Month May Day 3 Year 1961		
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-10-34		9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min. 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer			10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		
11. BIRTHPLACE (County & State, or foreign country) Michigan			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry B. ROHLOFF			14. MOTHER'S MAIDEN NAME Anna Mae PURCELL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 1956 to 1961 377-30-0979		
17. INFORMANT (W) Mrs. Marilyn A. Rohloff, same as # 2 above			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, acute, monocytic DUE TO (b) 204.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 months		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (his hospital) attended the deceased from Dec. 22 1960 to May 3 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 3 1961 and that death occurred at 12:35 PM from the causes and on the date stated above.					
22a. SIGNATURE Joseph E. Stitcher M.D.			22b. DATE SIGNED 5-3-61		
22c. PHYSICIAN'S NAME (Type) Joseph E. STITCHER, LT, MC, USN			22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-5-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia		23f. REC'D BY REGISTRAR DATE MAY 5 '61	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Inc.		ADDRESS 3072 M St., NW, Washington, DC		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

VR A15 (4)
15M 9/60

W. W. Chambers Co., 3012 M St., NW, Washington, DC

April 27-51

Arlington National

Arlington

Virginia

Joseph E. Stillman, Jr., MC, USN U. S. Naval Hospital, Bethesda, Md.

7-3-51

May 3 51

Dec. 22 1950
May 3 51

May 3 51

Leukemia, acute, monocytic

3 months

Yes 1956 to 1961 377-30-0779 (W) Mrs. Marilyn A. Holloft, same as 2 above

Henry B. Holloft

Anna Mae Poterell

Officer

U.S. Marine Corps

Michigan

USA

Male Caucasian

Albino

Holloft

May

51

U. S. Naval Hospital

25 Courtney Drive

132 days Triangle

Virginia

Monterey

Bethesda (Rural)

5863

CERTIFICATE OF DEATH

Reg. Dist. No. 05850

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. Virginia b. COUNTY Giles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Payne Last Ross		4. DATE OF DEATH Month May Day 23 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22-1911
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME James Hewitt		14. MOTHER'S MAIDEN NAME Martha Sarver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Albert Ross, Barnesville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease (Atherosclerosis) DUE TO (c) Hypertensive-Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH 20 minutes 8 months 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 May 19 59 , to 23 May 19 61 , that I last saw the deceased alive on 23 May 19 61 , and that death occurred at 11:03 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 27 May 61	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/26/61	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) (State) Beallsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR DATE MAY 31 '61	
ADDRESS Barnesville, Md		24b. REGISTRAR'S SIGNATURE Arthur L. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1963

STATE OF MARYLAND

County of Baltimore
City of Baltimore
7 yrs

James Howitt
Bertha
Rose
Helen
61

Female
White
House wife
Virginia

March 28-1911
Mortimer
Robert Rose, Baltimore, Md

James Howitt
Bertha
Rose
Helen

Female
White
House wife
Virginia

March 28-1911
Mortimer
Robert Rose, Baltimore, Md

James Howitt
Bertha
Rose
Helen

Female
White
House wife
Virginia

Baltimore, Maryland

Monetary

1963

James

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5864
CERTIFICATE OF DEATH
05851

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9809 Montauk Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Frances		First Frances		Middle ROZNOSKI		Last May		4. DATE OF DEATH Month 25 Day 19 Year 61			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-7-86		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 25 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin ROZNOSKI				14. MOTHER'S MAIDEN NAME Katherine (unknown)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT (D) Mrs. Laverne Koon, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Malignant Tumor Conditions, if any, which gave rise to immediate cause (b) 3 weeks (a), stating the underlying cause last. (c) 3 years										INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
12a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				12b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
12c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				12d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		12e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		12f. (City or town) May 15 1961		12g. (County) Toledo	
12h. (State) Ohio				12i. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 15 1961 to May 25 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 25 1961 , and that death occurred at 6:08AM , from the causes and on the date stated above.											
22a. SIGNATURE James M. Young M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5-25-61			
22c. PHYSICIAN'S NAME (Type) James M. YOUNG, LT, MC, USN				22d. ADDRESS U. S. NAVAL HOSPITAL, BETHESDA, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				23b. DATE THEREOF 5-26-61		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town or county) Toledo		23e. (State) Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE MAY 29 '61		25b. REGISTRAR'S SIGNATURE Charles S. Frank	

(M)

Management

Management

Management

Boothman (Rural)

Boothman

Boothman

U. S. Naval Hospital

9000 Montclair Avenue

Francis

Francis

Francis

Female

Caucasian

X

11-7-36

74

Howatville

Ohio

U.S.A.

Medical Hospital

Washington (Unknown)

None

(b) Mrs. Lawrence Noon, same as above

(I)

X

MAY 23

61

MAY 23 4:03 PM '61

MAY 23

61

X

James M. Young, Jr., MD, USN

U. S. NAVAL HOSPITAL, BENNETT, MD.

Medical-Surgical 5-25-61

Gynecology Gynecology

Toledo

Ohio

H. A. Thompson, M.D., Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5865
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		MARYLAND c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3854 North Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle Emmerson Last Runion		4. DATE OF DEATH Month May Day 16 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1954	9. AGE (In years last birthday) 6 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Owen Runion		14. MOTHER'S MAIDEN NAME Avis Funkhouser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Congenital Heart Disease, Tetralogy of Fallot DUE TO (c) Corrective cardiac surgery		INTERVAL BETWEEN ONSET AND DEATH Immediate 6 years 6 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) May 14, 1961 to May 16, 1961	
20f. (City or town) May 14, 1961 to May 16, 1961		(County) May 14, 1961 to May 16, 1961		(State) May 14, 1961 to May 16, 1961	
21. I certify that (I) (this hospital) attended the deceased from May 14, 1961 to May 16, 1961 , that (I) (we) last saw the deceased alive on May 16, 1961 , and that death occurred at 6:30 p.m. from the causes and on the date stated above.					
22a. SIGNATURE Allan Goldblatt		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/17/61	
22c. PHYSICIAN'S NAME (Type) ALLAN GOLDBLATT, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 5-17-61		23b. DATE THEREOF 5-17-61		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	
23d. LOCATION (City, town, or county) Faulks Run, Virginia		(State) Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAY 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. House					

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Time of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

1

5866

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05853

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saboma Park</i>				c. LENGTH OF STAY IN 1b <i>years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7111 Carroll Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>SEMU</i> Middle <i>-</i> Last <i>SATO</i>				4. DATE OF DEATH Month <i>5</i> Day <i>11</i> Year <i>1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Oriental</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 19, 1880</i>		9. AGE (In years last birthday) <i>80</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Japan</i>		12. CITIZEN OF WHAT COUNTRY? <i>Japan</i> ✓	
13. FATHER'S NAME <i>Yamauchi</i>		14. MOTHER'S MAIDEN NAME <i>Not Available</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mrs. Florence Nishimoto</i> Address <i>7409 Holly Ave. Jct. Pk. Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive failure & hypertension</i> DUE TO (c) <i>Cerebrovascular accident</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVAL BETWEEN ONSET AND DEATH</i> <i>24h.</i> <i>5yrs.</i> <i>5yrs.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 3-11</i> 19 <i>61</i> , to <i>May 11</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>May 11</i> 19 <i>61</i> , and that death occurred <i>6:25 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Ernest A. Sarao</i>				22b. DATE SIGNED <i>5/11/61</i>		22c. PHYSICIAN'S NAME (Type) <i>ERNEST A. SARAO</i>	
22d. ADDRESS <i>7006 New Hampshire Ave. Jct. Pk. Md.</i>				22e. REC'D BY REGISTRAR <i>May 15 '61</i>			
22f. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>				23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>			
23b. DATE THEREOF <i>May 13, 1961</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Crematory</i>			
23d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>				24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Hines</i>			
24a. ADDRESS <i>254 Carroll St. N.W. D.C.</i>				24b. DATE <i>MAY 15 '61</i>			

3868

CERTIFICATE OF DEATH

1924

[Faint, mostly illegible text from the reverse side of the document, including names and dates.]

1

5867

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

05854

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck (Rural)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARRIE Middle SATTERFIELD Last SATTERFIELD				4. DATE OF DEATH Month May Day 21 Year 1961			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1889	
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland.				12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME Lawrence Braxton				14. MOTHER'S MAIDEN NAME Barry Luckett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Hazel Kennedy				Address 2001 Maryland Ave., N. E. Wash. D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma generalized 170X DUE TO Breast Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension C.R.D.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 30, 1960 to May 21, 1961 , that (I) (we) last saw the deceased alive on May 20, 1961 , and that death occurred at 1:12 PM from the causes and on the date stated above.							
22a. SIGNATURE Debita Jewell				22b. DATE SIGNED 5-24-61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National.		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				25a. REC'D BY REGISTRAR DATE MAY 29 '61			
				25b. REGISTRAR'S SIGNATURE Arthur L. Jones			

OFFICE OF DEATH

January

California

1. 1. 1. 1. 1

BATTLES

June 22, 1888

Warwick

Barry, Joseph

The Great Highway 2001, London, W. 1, 1
1888, D. 1, 1

Warwick (1888)

Warwick (1888)

Warwick

Warwick (1888)

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Warwick (1888)

Warwick, 1888

Warwick (1888)

Warwick (1888)

Warwick (1888)

Warwick, 1888

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G287 5/15/61 jwk

CERTIFICATE OF DEATH

Reg. Dist. No. 05855

5868

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	c. LENGTH OF STAY IN 1b 3½ years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase SS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4604 DeRussey Parkway		d. STREET ADDRESS 4604 DeRussey Parkway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle M. Last SCHNEIDER		4. DATE OF DEATH Month May Day 6 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 11 Days 27	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME George Brandt		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter		Address 4868 Ch. Ch. Blvd. Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, left, acute 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Arteriosclerosis, generalised.			INTERVAL BETWEEN ONSET AND DEATH 7 days. synst
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1946 to May 6, 1961 , that I last saw the deceased alive on May 5, 1961 , and that death occurred at 930 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4740 Chevy Chase Dr. 5.6.61 DATE SIGNED Stewart Clapp ACTUAL SIGNATURE Stewart Clapp M.D. Chevy Chase, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-9-61	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR DATE MAY 9 '61
		24b. REGISTRAR'S SIGNATURE Arthur L. Thrall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5869

CERTIFICATE OF DEATH

Reg. Dist. No.

05856

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northampton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Gardens Nursing Home		d. STREET ADDRESS 58X-3	
3. NAME OF DECEASED (Type or print) Mary First A. T. Middle Schoeneck Last		4. DATE OF DEATH May Month 12 Day 61 Year 19	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 31, 1876
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Mother		10b. KIND OF BUSINESS OR INDUSTRY Smith Collage	
11. BIRTHPLACE (State or foreign country) New York City, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Speight		14. MOTHER'S MAIDEN NAME Mary Marvin Todd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 019-26-0836	
INFORMANT Mrs Edith F. Thomas		Address Silver Spring, Md. 2238 Washington Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Hyperpyrexia (Influenza?) DUE TO Arteriosclerosis, Generalized with Cerebral Degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Degeneration (c) Cerebral Degeneration INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 1961 to May 12, 1961 , that I last saw the deceased alive on May 12, 1961 , and that death occurred at 10:30 pm , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibadeau		ADDRESS (Street, city or town, state) 10609 Concord Street May 12, 61	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial 5/16/61		22b. DATE THEREOF 5/16/61	
22c. NAME OF CEMETERY OR CREMATORY Fountain Hill Cemetery		22d. LOCATION (City, town, or county) (State) Deep River, Middlesex Co., Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE MAY 17 '61	
24b. REGISTRAR'S SIGNATURE Carlton S. Fine			

CERTIFICATE OF DEATH

1962

M

1. Name of deceased: _____

2. Sex: _____

3. Date of birth: _____

4. Place of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of filing: _____

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5870

05857

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 41 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 2113 Flyers Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Louis Middle Frank Last SHABEK		4. DATE OF DEATH Month May Day 17 Year 19 61		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-29-88		9. AGE (In years last birthday) 72 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months	Days																		
Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME James SHABEK				14. MOTHER'S MAIDEN NAME Mary SMITH				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or date of service) WW #1											
16. SOCIAL SECURITY NO. 577-48-4778A				17. INFORMANT Mrs. Mary L. Shabek, same as #2 above				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma toxic DUE TO (b) Carcinoma of pancreas DUE TO (c) 157X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 6, 1961 to May 17, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 17, 1961 , and that death occurred at 11:05 PM , from the causes and on the date stated above.																			
22a. SIGNATURE C. W. Bramlett M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5-18-61											
22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 5/19/61		23c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery				23d. LOCATION (City, town or county) (State) Defuniak Springs Florida											
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Biska				25a. REC'D BY REGISTRAR DATE MAY 23 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

after

Bethesda (Rural)

U. S. Naval Hospital

Louis

Cemetary

Mariner

James SHAW

Yes

at large

River Spring

2113 Pipers Hill Road

CHADAK

Frank

10-29-88

TS

U. S. Navy

Maryland

MARY SMITH

277-62-7774 (W) Mrs. Mary L. Shaber, same as 2 above

April 6 11:02 AM

5-18-81

C. W. BRAMLEY, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Regolia Cemetary

Delmar Springs

2113 Pipers Hill Road, River Spring, Md.

TO HOST FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5871

05858

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 hrs. 40 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Elizabeth's</u>				d. STREET ADDRESS <u>3602 - Riet St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward H. Shorman</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/01</u>	9. AGE (In years, if UNDER 1 YEAR, last birthday) <u>59</u> yrs.		IF UNDER 24 HRS. Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woodward & Lothrop</u>		11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George F. Shorman</u>				14. MOTHER'S MAIDEN NAME <u>Justine Sweeney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>not</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Dorothy R. Shorman</u> Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, left</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Essential Hypertension, severe</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>5 yrs.</u> <u>25 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis, old.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950 to May 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1961</u> , and that death occurred at <u>6:50 P.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-19-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		23b. DATE THEREOF <u>5/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Auburn, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 23 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05854

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> M b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sunshine</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R-1 Brookville</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mont</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sunshine</u> d. STREET ADDRESS <u>R-1 Brookville</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert Murphy Shearer</u>				4. DATE OF DEATH <u>May 21 1961</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12-19-1900</u>		9. AGE (in years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Shearer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Murphy</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>185-30-3884</u>		17. INFORMANT <u>Emilie J. Campbell</u> Address <u>Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> 976X DUE TO (b) <u>Shot gun wound of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound</u>					
20c. TIME OF INJURY Month, Day, Year <u>5-21 1961</u> Hour a.m. <u>3</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Sunshine</u> (County) <u>mont</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-21-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5-24-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East Waterford</u>		22d. LOCATION (City, town, or country) (State) <u>East Waterford, Penn.</u>			
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

(M)

(I)

MEDICAL CERTIFICATION

2

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100-30-581

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610754 5 15-8

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• 2000

TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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5873
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05860

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 6439 2nd Place, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mollie Middle None Last Sindler		4. DATE OF DEATH Month May Day 25 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1959
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Sindler		14. MOTHER'S MAIDEN NAME Marilyn Friedman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Niemann-Pick Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 289.0 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 20 19 61 , to May 25 19 61 , that (I) (we) last saw the deceased alive on May 25 19 61 , and that death occurred at 2:15 AM from the causes and on the date stated above.			
22a. SIGNATURE Alexander Deutsch		22b. DATE SIGNED 5-25-61	
22c. PHYSICIAN'S NAME (Type) Alexander Deutsch M.D.		22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 25, 1961	
23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery		23d. LOCATION (City, town, or county) (State) Elmont, Long Island N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home		25a. REC'D BY REGISTRAR MAY 29 '61	
ADDRESS 4217 9th Street N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1913

1. Name of deceased: *John J. Smith*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *May 15, 1913*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Signature of physician: *John J. Smith*
8. Signature of registrar: *John J. Smith*
9. Signature of coroner: *John J. Smith*

10. Name of informant: *John J. Smith*
11. Address of informant: *123 Main St., Albany, N.Y.*
12. Signature of informant: *John J. Smith*
13. Date of report: *May 15, 1913*
14. Signature of registrar: *John J. Smith*
15. Signature of coroner: *John J. Smith*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5874

Items 23a & d, Film 9287 5/15/61 1vk

05861

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 21 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aldie d. STREET ADDRESS P.O. Box 171 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nina Middle Marie Last Smallwood		4. DATE OF DEATH Month May 8, Day 19 Year 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1956
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Smallwood		14. MOTHER'S MAIDEN NAME Ruby M. Poston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram negative septicemia DUE TO (b) Acute lymphatic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 2 days 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from April 17, 1961 to May 8, 1961 that he (we) last saw the deceased alive on May 8, 1961 , and that death occurred at 1:35 PM from the causes and on the date stated above.			
22a. SIGNATURE Richard E. Rieselbach		22b. DATE SIGNED 5/8/61	
22c. PHYSICIAN'S NAME (Type) Richard E. Rieselbach, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.	23b. DATE THEREOF 5/10/61	23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	23d. LOCATION (City, town, or county) (State) Round Hill, Virginia. Upperville
24. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Birch's		25a. REC'D BY REGISTRAR DATE MAY 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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I

Montgomery

Bethesda

The Clinical Center

Room 10

Female White

Child

Robert H. Hines

Room

Room

Room

Virginia

November 25, 1955

Washington

May 6

P.O. Box 171

Miss

21 days

Virginia

London

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>50 Bethesda</u> d. STREET ADDRESS <u>4712 Smith Chelsea Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Harvey L. Smith</u> First Middle Last		4. DATE OF DEATH <u>May 20 1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/89</u> Last
9. AGE (In years last birthday) <u>72</u> yrs.		10. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert J. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Matthacutagar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>15444</u>	
17. INFORMANT <u>Frances T. Smith</u> Address <u>15444</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>539.0</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>As a consequence of</u> (a), stating the underlying cause last, (c) <u>Chronic atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced generalized arteriosclerosis</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 20 1961</u> to <u>May 20 1961</u> , that (I) (we) last saw the deceased alive on <u>May 20 1961</u> , and that death occurred at <u>5 M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Pumphrey</u> M.D.		22b. DATE SIGNED <u>May 20 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Pumphrey</u>		22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 23 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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Robert A. Humphrey, Bethesda, Maryland
5/24/61
Action Nat. Dem.
Arlington, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)			
a. COUNTY				a. STATE		b. COUNTY	
Montgomery MARYLAND				MD (D.C.)		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Bethesda		45 days		Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
Suburban Hospital				5117 Scarsdale Rd.			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
Julia A Smith				May 10 61			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8/9/01	
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
59 yrs.				Austria		U.S.A 1921	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JH Ludwig				Julia Ann Krompost			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
No				Yes Unknown			
17. INFORMANT				Address			
Son Robert Smith				3900 Tenlow Rd. Washington, D.C			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased Intracranial Pressure 4 days							
Conditions, if any, which gave rise to immediate cause (b) Cerebral Metastatic Disease 6 mo.							
causing the underlying cause last. (c) Carcinoma of the Breast 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19						20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-1, 1961, to 5-10, 1961, that (I) (we) last saw the deceased alive on 5-9, 1961, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
Francis Mayle				5/10/61		Francis Mayle	
22d. ADDRESS				22e. ADDRESS			
				8218 Wisconsin Ave Bethesda 14 MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Bur, Transit		5/12/61		Grandview Cemetery		Cambria County, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE				25. REC'D BY REGISTRAR			
Robert A. Pumphrey				MAY 15 61			
ADDRESS				25b. REGISTRAR'S SIGNATURE			
Bethesda, Maryland				Arthur S. Moore			

Conscience of the World
 Charles Webster
 Edmund L. Parker

James O. Thompson

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, any physician who executes the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 18 File 287-5-23-61</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05864</div>											
1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND				b. COUNTY MONTGOMERY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 7 days				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANITARIUM AND HOSPITAL				d. STREET ADDRESS 10107 Greenock Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Phyllis				First Wauna				Last Snow			
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8/16/13				9. AGE (In years last birthday) 47				10. IF UNDER 1 YEAR Months Days 5 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Oregon			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William Shepherd				14. MOTHER'S MAIDEN NAME Jean Martin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 537-24-7372				17. INFORMANT Hospital record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending Cerebral necrosis DUE TO Cerebral anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Undetermined DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart				M.D. Frank J. Broschart, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED May 5, 1961			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial				22b. DATE THEREOF May 9, 1961				22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			
22d. LOCATION (City, town, or country) Prince Georges Co., Md.				22e. (State) Md.							
23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Ave., S.S.				24a. REC'D BY REGISTRAR May 12 '61			
24b. REGISTRAR'S SIGNATURE Raymond A. Ziska				24c. REGISTRAR'S SIGNATURE Arthur S. Harris							

THE STATE
OF NEW YORK

(M)

(I)

1924

IN SENATE,
January 1, 1924.
REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS,
FOR THE YEAR
1923.

ALBANY:
JAMES B. LEE,
PRINTERS,
1924.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5878 CERTIFICATE OF DEATH 05865											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md.</u> b. COUNTY <u>Mont</u> 14							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 day 5 hrs.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Holly Grove Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marion B. Stewart</u>				4. DATE OF DEATH <u>May 21 1961</u>							
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/27/97</u>		9. AGE (In years last birthday) <u>64</u> Yrs.		IF UNDER 1 YEAR UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Wm. Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>331X</u>				17. INFORMANT <u>Ruth A. Slaughter R.F. #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>not known</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interval between onset and death 1 day</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>61</u> , to <u>5/21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>61</u> , and that death occurred at <u>5/21</u> , 19 <u>61</u> , M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Abraham W. Davis</u>				22b. DATE SIGNED <u>5/21/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DAVIS</u>				22d. ADDRESS <u>907 Rushing Rd. Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE HEREOF <u>5/26/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Church.,</u>			
23d. LOCATION (City, town, or county) <u>Highland, Md.</u>				(State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 29 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>											



11

1

Wilmington, N.C.

Hopkins Church

1881

1881

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

1 #
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 090
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 5879
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 05866

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md-</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>6 hrs-</u>				d. STREET ADDRESS <u>1901 Davis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>(Stilmar) Clara B. Stilmar</u>				4. DATE OF DEATH Month Day Year <u>May 28 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 15, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housew. & - teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Emmaline houx</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT (daughter) <u>Mrs. Edward Christianson</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1956</u> to <u>May 28 1961</u> , that (I) (we) last saw the deceased alive on <u>May 25 1961</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James M. Whitbeck MD</u>				22b. DATE SIGNED <u>5-28-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>James M. Whitbeck MD</u>				22d. ADDRESS <u>7717 Canall Ave, Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>May 29 - 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Haller</u> ADDRESS <u>254 Carroll St. N.E.</u>				25a. REC'D BY REGISTRAR <u>MAY 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Haller</u>	

CERTIFICATE OF BIRTH

1922

(M)

State of New York
County of New York
I, the undersigned, being a duly qualified Registrar of Births and Deaths, do hereby certify that on the 1st day of January, 1922, at New York City, New York, was born to Mr. and Mrs. John Doe a male child, the name of whom is John Doe, Jr., born at New York City, New York, and is now residing at New York City, New York.

Witness my hand and the seal of the Department of Health at New York City, New York, this 1st day of January, 1922.

Registrar of Births and Deaths

(1)

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1

5880

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05867

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>4yr 5mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>The Marylander</i>	
3. NAME OF DECEASED (Type or print) <i>Ethel Mary P. Storck</i>		4. DATE OF DEATH <i>May 1</i> 1961	
5. SEX <i>female</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 27 1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Woodward & Lothrop</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Department Store</i>	11. BIRTHPLACE (State or foreign country) <i>New York</i>
13. FATHER'S NAME <i>Martin Mapes</i>		14. MOTHER'S MAIDEN NAME <i>Hattie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>579-37-3792</i>	17. INFORMANT <i>Ethel H. Storck</i> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Probable myocardial infarction</i> DUE TO (b) <i>Arteriosclerotic cardiovascular disease (many signs)</i> DUE TO (c) <i>lying cause lost.</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None of significance</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2/23</i> 19 <i>57</i> to <i>5/1</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>5/1</i> 19 <i>61</i> , and that death occurred at <i>8:30</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>John P. Martin, MD</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JOHN P. MARTIN MD</i>		22d. ADDRESS <i>MEDICAL CENTER, SANDY SPRING</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 4, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>	23d. LOCATION (City, town, or county) (State) <i>Falls Church, Virginia</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>DATE MAY 3 '61</i>	
ADDRESS <i>254 Carroll St NW DC</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

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5881

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05868

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>			
c. LENGTH OF STAY IN 1b <i>12 yrs</i>				d. STREET ADDRESS <i>Cummings Lane</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3282 Cummings Lane</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Guillermo A. Suro</i>				4. DATE OF DEATH <i>May 12 1961</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-7-1907</i>	
9. AGE (In years) <i>54</i> yrs.		10. AGE UNDER 1 YEAR		11. AGE UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief Publications</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Pan Am. San Bureau</i>			
11. BIRTHPLACE (State or foreign country) <i>Porto Rico</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.C</i>			
13. FATHER'S NAME <i>G. Suro - Parado</i>				14. MOTHER'S MAIDEN NAME <i>Carmen Suro Nunez</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>217-42-8463</i>			
17. INFORMANT <i>Riudad - Suro</i>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<i>History of previous coronary attack</i>							
20a. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. (City or town)				20e. (County)		20f. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>5-12-61</i>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>MAY 15, 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>		22d. LOCATION (City, town, or country) (State) <i>SILVER SPRING, MD.</i>	
23. FUNERAL DIRECTOR <i>Joseph L. Suro's Sons, WASH., D.C.</i>				24a. REC'D BY REGISTRAR <i>MAY 15 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Suro</i>	

BP

1922

STATE OF MARYLAND

(M)

(1)

MD

1922

FRANK J. BROWN

DECEASED

1922

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5882 CERTIFICATE OF DEATH 05869											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>IOWA</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1912 So Wilson</u>				c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MASON CITY</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>						d. STREET ADDRESS <u>53X-3</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Victor Warren Swartz</u>						4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MASON CITY, IOWA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ANTONE CASPER SWARTZ</u>						14. MOTHER'S MAIDEN NAME <u>MARGARITE COOK</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>482-32-1798</u>		17. INFORMANT <u>CHARLOTTE SWARTZ</u>		Address <u>1912 S. Wilson, Mason City, Iowa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary emboli, multiple</u> 465X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple superficial Gastric Ulcers</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12 April 1961</u> to <u>MAY 1 1961</u> , that (I) was last saw the deceased alive on <u>MAY 1 1961</u> , and that death occurred at <u>12:30 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Jack Crowell</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 1, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>JACK CROWELL</u>						22d. ADDRESS <u>2025 EYE ST. N.W. Washington, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried 5/4/61</u>		23b. DATE THREE OF		23c. NAME OF CEMETERY OR CREMATORY <u>Fair Lawn Cem.</u>		23d. LOCATION (City, town or county) <u>Rockville Pk Md</u>		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>						ADDRESS <u>5103 Wilson Wash DC</u>		25a. REC'D BY REGISTRAR <u>MAY 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5883
CERTIFICATE OF DEATH
65870

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Virginia b. COUNTY Campbell c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lynchburg d. STREET ADDRESS 1403 Club Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Cheryl Lynn Tarkington				4. DATE OF DEATH Month Day Year May 22 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1952	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward H. Tarkington				14. MOTHER'S MAIDEN NAME Jean Richcreek			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 2043 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute lymphatic leukemia (c) 2043 DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 5 minutes 15 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr (this hospital) attended the deceased from May 16 19 61 to May 22 19 61 , that Dr (we) last saw the deceased alive on May 22 19 61 , and that death occurred at 11:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE Richard E. Rieselbach, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 5/22/61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Richard E. Rieselbach, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town or county) (State) Lynchburg, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. D. Dinguid Inc				ADDRESS Lynchburg, Virginia		25a. REC'D BY REGISTRAR DATE MAY 25 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

(1)

Montgomery	Virginia	Cardwell
Between	5 days	Washington
The Clinical Center, Bethesda, Md.	May 15, 1952	May 15, 1952
Female	White	None
Student	None	U.S.A.
Edward R. Tarrington	John R. Tarrington	The Clinical Center, Bethesda, Md.
None	None	None

May 15, 1952 of May 15, 1952 of May 15, 1952 of

... National ... of Health, Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5884

05871

Item 9 Film 0287 5/17/61

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 75 MINUTES	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 2920 MCKINLEY ST., N. W.	
3. NAME OF DECEASED (Type or print) First EVELYN Middle --- Last TECKEMEYER		4. DATE OF DEATH Month MAY Day 11 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1906
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 5 Days 5 IF UNDER 24 HRS. Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY TENNESSEE	
11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MATTINGLY		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address HOSPITAL, RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ACUTE PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2:50 PM 5/11 1961 to 3:36 PM 5/11 1961 , that (I) (we) last saw the deceased alive on 5/11 1961 , and that death occurred at 3:36 PM , from the causes and on the date stated above.			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE THEREOF 5/13/61	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	23d. LOCATION (City, town, or county) Bladensburg Rd. Md (State)
24. FUNERAL DIRECTOR'S SIGNATURE Cheng Cheng Funeral Home, Wash Dc		25. REC'D BY REGISTRAR May 15 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Evans			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1

W.C. 111

Office Building

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
STATE OF NEW YORK

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE

TIME

PLACE

CAUSE

SEX

AGE

DATE

TIME

PLACE

CAUSE

SEX

DATE

TIME

PLACE

CAUSE

DATE OF DEATH

TIME OF DEATH

Signature of Physician
Signature of Registrar
Signature of Coroner

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5885
CERTIFICATE OF DEATH
05872

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Convalescent Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>606629-81st St, Cabin John, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thornton</u> Middle <u>B</u> Last <u>Titus</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1875</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. FUND 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Titus</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann McKimmy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-24-4693</u>	
17. INFORMANT <u>Elizabeth Witt-6629-81st St.</u>		Address <u>Cabin John Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS GENERAL</u> DUE TO (c) <u>5 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 1959</u> to <u>MAY 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>MAY 21, 1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Leo M. Curtis</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>		22d. ADDRESS <u>8218 WISCONSIN AVE., BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		23d. LOCATION (City, town, or county) (State) <u>Leesburg, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 25 '61</u>	
ADDRESS <u>-1331 F. Montg. Ave. Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

5886

05873

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME				d. STREET ADDRESS 8110 New Hampshire Ave. FAIRLAND, M.D.			
3. NAME OF DECEASED (Type or print) First FRANCES Middle ULRICH Last ULRICH				4. DATE OF DEATH Month MAY Day 16 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 6 Days 17		IF UNDER 24 HRS. Hours 16 Min. 16			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES WOMAN				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SOLOMON KRASNER				14. MOTHER'S MAIDEN NAME HANNAH EISENBERG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 577-36-2724			
17. INFORMANT STANLEY K. ULRICH - 8110 NEW HAMPSHIRE AVE				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of the sigmoid 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11 19 60 to 5/15 19 61 , that I last saw the deceased alive on 5/15 19 61 , and that death occurred at 8 A.M. from the causes and on the date stated above. Beth Kaler BENNETT A. ROBIN, M.D. DATE SIGNED ACTUAL SIGNATURE M.D. 317 UNIV. BLVD. EAST SILVER SPRING, MD. JU. 8-8700							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/18/61		22c. NAME OF CEMETERY OR CREMATORY BETH DAVID CEMETERY ELMONT-L.I., N. Y.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY-SONS ADDRESS 3501-14 STNW				24a. REC'D BY REGISTRAR MAY 18 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thoma	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TENNESSEE

1928

(M)

(I)

BERNARD A. BROWN
JULY 1928
JULY 1928

1
FOR STATE-
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5887

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 6 Film G286

5/8/61 ink

05874

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>De.</u> b. COUNTY <u>De.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>1 mo</u>				d. STREET ADDRESS <u>3847 Rockman St. N.W.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Garden Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Lawrence Vaile</u>				4. DATE OF DEATH <u>May 1 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-11-78</u>	
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker - Retired</u>				11. BIRTHPLACE (State or foreign country) <u>Ill.</u>			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>John Vaile</u>				14. MOTHER'S MAIDEN NAME <u>Narcissia Lawrence</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>441-01-1084</u>			
17. INFORMANT <u>Nursing Home Record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 442X DUE TO (b) <u>Chronic Cardiac - Renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>May 1-1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/3/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAY 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN b 17 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton		d. STREET ADDRESS 11967 Andrew Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) U. S. Naval Hospital		First Marin		Middle Pierre		Last VINCENT		4. DATE OF DEATH Month May		Day 21		Year 19 61			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-92		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68		Days 68		Hours 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (County & State, or foreign country) France		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Desiree VINCENT		14. MOTHER'S MAIDEN NAME Zenaide BONTOUS													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. (S) Rene N. Vincent, 2702 10th St., NE, WashDC		17. INFORMANT (S) Rene N. Vincent, 2702 10th St., NE, WashDC		Address (S) Rene N. Vincent, 2702 10th St., NE, WashDC									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 4 1961, to May 21 1961		(County) Washington		(State) D.C.					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 4 1961 to May 21 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 21 1961 and that death occurred at 5:27 PM from the causes and on the date stated above.															
22a. SIGNATURE Robert G. Muth		M.D. Robert G. MUTH, LT, MC, USN		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-22-61					
22c. PHYSICIAN'S NAME (Type) Robert G. MUTH, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Washington		(State) D.C.							
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Mt. Ranier, Md.		ADDRESS W. F. N.		25a. REC'D BY REGISTRAR MAY 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

VR A15 (4)
15M 9/60

M

Monterey

Beach (Hill)

17 days

Whisper

U. S. Naval Hospital

11907 New Street

Marin

Plume

VINCENT

May

21

RI

Occasional

7-20-25

83

Clifford

Hotel

France

USA

Darius VINCENT

Manila Point

No

Arteriosclerosis, generalized

years

x

May 21

May 2

5:25 PM

May 21

May 2

7-22-21

Robert G. Hunt, Jr., MD, USA

U. S. Naval Hospital, Bethesda, Md.

Serial

2-24-21

Mc. Oliver Cemetery

Washington

DTC

Robert's Personal Name, Mc. Hunter, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

BP

16
FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
5889											
05876											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					
c. LENGTH OF STAY IN 1b <u>23 yrs</u>						d. STREET ADDRESS <u>9118 Redwood Avenue</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9118 Redwood Ave</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Elliott Lambert Wallace</u>						4. DATE OF DEATH <u>May 27 1961</u>					
5. SEX <u>male</u>						6. COLOR OR RACE <u>white</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>6-8-1878</u>					
9. AGE (In years last birthday) <u>82</u> yrs						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. employee</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>					
11. BIRTHPLACE (State or foreign country) <u>Us</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Geo. M. Wallace</u>						14. MOTHER'S MAIDEN NAME <u>Elij. Roberts</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Julia Wallace (wife)</u>						Address <u>Strm 2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>5-27-61</u>					
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/31/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			
								22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>						24a. REC'D BY REGISTRAR <u>JUN 2 '61</u>					
						24b. REGISTRAR'S SIGNATURE <u>Clifford S. Huns</u>					

• **Nov 11**

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

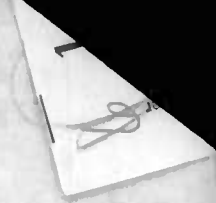
5890

45877

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 35 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 407 3rd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hannah Catherine WERT				4. DATE OF DEATH Month May Day 19 Year 61			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-6-80	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Christ RONK				14. MOTHER'S MAIDEN NAME Mary E. DULL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (S) Charles A. Wert, Jr., same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 420.0 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Staphylococcal pneumonia (2 weeks) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 48 hours 10 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that it (this hospital) attended the deceased from April 14, 1961 to May 19, 1961 , that it (we) last saw the deceased alive on May 19, 1961 , and that death occurred at 12:35AM , from the causes and on the date stated above.							
22a. SIGNATURE James M. Young M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-19-61	
22c. PHYSICIAN'S NAME (Type) James M. YOUNG, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery		23d. LOCATION (City, town or county) (State) Elizabethville Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE R. J. Murphy				ADDRESS Arlington, Va.		25a. REC'D BY REGISTRAR MAY 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanks							

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



U. S. Naval Hospital
Bethesda (Rural)
35 days
Maryland
And Arnold
Hennrich
Catherine
Mary
19
01
2-6-30
Pennsylvania
USA
Charles R. Hull
Mary E. Hull
(3) Charles A. Hull, Jr., same as his above
None

James M. Young, Lt. MC, USN
U. S. Naval Hospital, Bethesda, Md.
April 19 01
May 19 01
12:35 PM
K
3-19-01
Baptist Hospital
Baltimore, Md.
U. S. Naval Hospital, Bethesda, Md.
May 19 01
12:35 PM
K
3-19-01

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2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5891											
05878											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Virginia b. COUNTY Manassas							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 191 Old Centreville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
		Robin		Denise		WEST		May		30 19 61	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-29-61		9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Leon WEST, JR.						14. MOTHER'S MAIDEN NAME Phyllis Carol ROBBINS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Fred L. West, Jr., same as #2 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (b) causing the underlying cause last. (c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prolapsed umbilical cord with asphyxia											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 29 1961 to May 30 1961		20g. (County) 9:45AM		20h. (State) 1961	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 29 1961 to May 30 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 30 1961 , and that death occurred at 9:45AM , from the causes and on the date stated above.											
22a. SIGNATURE G. B. Avery, LT, MC, USN				22b. DATE SIGNED 5-31-61				22c. PHYSICIAN'S NAME (Type) G. B. Avery, LT, MC, USN			
22d. ADDRESS U S. Naval Hospital, Bethesda, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-1-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				24b. ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR JUN 1 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

VR A15 (4)
15M 9/60

2051223XV3

(M)

(C)

(1)

Montgomery

Bethesda (Annapolis)

U. S. Naval Hospital

Florida

California

Fort Belvoir, Ill.

Home

Virginia

Washington

101 Old Georgetown Road

Way

2-25-51

Maryland

Phyllis Carol Hastings

(7) 1710 D. Wood, Jr., Suite 202, 4800

Marble

0-1-51

Arlington National

Arlington

Virginia

R. A. Thompson, Personal Home, Bethesda, Md.

G. B. Vandy, Jr., MC, USN

U. S. Naval Hospital, Bethesda, Md.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5892

05879

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Levy Last White				4. DATE OF DEATH Month May Day 15 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 5, 1899	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 16 Days X Hours 2		11. IF UNDER 24 HRS. Hours 2 Min.			
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent				10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Lee White				14. MOTHER'S MAIDEN NAME Nettie Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unavailable			
17. INFORMANT The Medical Record				18. ADDRESS The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphocytic leukemia DUE TO 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from May 15, 1961 to May 15, 1961 that (I) (we) last saw the deceased alive on May 15, 1961 and that death occurred at 2:05 P.M. from the causes and on the date stated above.							
22a. SIGNATURE R. Rieselbach				22b. DATE SIGNED 5/15/61			
22c. PHYSICIAN'S NAME (Type) R. Rieselbach M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		May 17-61		Christ Church		Clinton Md	
24. FUNERAL DIRECTOR'S SIGNATURE Simmors Bros				25a. REC'D BY REGISTRAR 1661 9th Hope Rd SE			
25b. REGISTRAR'S SIGNATURE Wash DC				DATE MAY 17 '61			

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2. *Case*

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

U5880

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7815 GREENWOOD AVE</u>				d. STREET ADDRESS <u>1 GREENWOOD AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
<u>EDNA FLOSSIE WILLARD</u>				<u>MAY 2, 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 27, 1888</u>	9. AGE (In years lost birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MORGANTOWN, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ZARQUELL</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. LEMON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GEORGIA M. WILLARD, 7815 GREENWOOD AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pulmonary Embolism susp.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>20 yr. est.</u> (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 22, 1960</u> to <u>May 2, 1961</u> , that (I) was last saw the deceased alive on <u>May 2, 1961</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph F. Patten</u>				22b. DATE SIGNED <u>5/2/61</u>		22c. PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN M.D.</u>	
22d. ADDRESS <u>8641-Colesville Road Silver Spring Md</u>				22e. REC'D BY REGISTRAR <u>MAY 3 '61</u>			
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>			
23b. DATE THEREOF <u>MAY 5, 1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>FLETCHER M. E. CEMETERY</u>			
23d. LOCATION (City, town, or county) <u>MORGANTOWN</u>				23e. LOCATION (City, town, or county) <u>W. VA.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>254 CARROLL ST NW</u>				24b. ADDRESS <u>WASH DC</u>			

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THE UNIVERSITY OF CHICAGO PRESS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59
Now

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS NORWOOD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) GARY ROBERT WILLET						4. DATE OF DEATH MAY 4 19 61						5. SEX MALE											
6. COLOR OR RACE WHITE						7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 8/12/60											
9. AGE (In years last birthday) yrs. 8						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.											
12. CITIZEN OF WHAT COUNTRY? U. S. A.						13. FATHER'S NAME ROBERT WILLET						14. MOTHER'S MAIDEN NAME RUTH REID											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. ITEM 2						17. INFORMANT RUTH REID											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) 47 SX ASPHYXIA DUE TO (b) UPPER RESPIRATORY INFECTION DUE TO (c) COLLAPSED IN BED. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												INTERVAL BETWEEN ONSET AND DEATH FOUND											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
22a. BURIAL, CREMATION, REMOVAL (Specify) XXXXXX												22b. DATE THEREOF May 6, 1961				22c. NAME OF CEMETERY OR CREMATORY Parklawn				22d. LOCATION (City, town, or country) (State) Montgomery Maryland			
23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.												ADDRESS 8434 Georgia Ave, S.S.				24a. REC'D BY REGISTRAR MAY 8 '61				24b. REGISTRAR'S SIGNATURE Carlton L. Hines			

5894
65881

ACTUAL SIGNATURE *Frank J. Broschart*
EXAMINER'S NAME (Type) **FRANK J. BROSCART, M. D.**

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED **5/4/61**

UNITED STATES
NAVY
15

(M)

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CLAY

NO

SILVER SPRING

FOR AND ROAD

GENERAL HOSPITAL

ROBERT WILSON

CLAY

WAT

WIT-ER

THE WHITE

WASHINGTON, D.C.

JOHN KYLE

ROBERT LEE

BUTHERS

ITEM 5

APPLYING

UPPER RESPIRATORY INFECTION

FOUND

COLLAPSED

IN BED

X

X

12/1/51

12/1/51

12/1/51

12/1/51

12/1/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased may be retained by the hospital or attending physician, the law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5895

05882

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Syn. & Hosp.</u>				e. STREET ADDRESS <u>1512 Noyes Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Gertrude Josephine Williams</u>				4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED: <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-88</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. AGE (In years last birthday) <u>72</u> yrs.		11. IF UNDER 1 YEAR Months <u>7</u> Days <u>26</u>		12. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswf</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Garison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Ralph Williams</u>				18. ADDRESS <u>10118 Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease & Hypertension</u> DUE TO (c) <u>over 10 years</u>				19. INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Myocardial Infarction 1955 & 1958</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not-While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 to <u>MAY 3</u> , 1961, that (I) <u>yes</u> last saw the deceased alive on <u>May 1</u> , 1961, and that death occurred at <u>6:12</u> p.m. from the causes and on the date stated above.							
22a. SIGNATURE <u>Warren D. Brill, M.D.</u>				22b. DATE SIGNED <u>May 1, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Warren D. Brill, M.D.</u>				22d. ADDRESS <u>2601-16th St. N.W. Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 6, 1961</u>				23b. DATE THEREOF <u>May 6, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>				23d. LOCATION (City, town or county) (State) <u>Prince Georges Maryland</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>May 8 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>				25c. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

VR A15 (4)
15M 9/60

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Wm. F. D. W. D.

2001 York St. New York

Wm. F. D. W. D.

Wm. F. D. W. D.

Wm. F. D. W. D.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5896

05883

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>130th St</u> c. LENGTH OF STAY, IN hrs <u>8 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Dist. of Columbia</u> D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1321- Harvard St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Palmer Wright</u> First Middle Last				4. DATE OF DEATH <u>May 17 1961</u> Month Day Year			
5. SEX <u>male</u> 6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>6/19/15</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years, last birthday) <u>47</u> 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County, State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Julius Wright</u> 14. MOTHER'S MAIDEN NAME <u>Abbie Palmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes World War II</u> 16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs. Elizabeth McNeal - Sister</u> Address <u>(same)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory FAILURE</u> DUE TO (b) <u>Cerebral Hemorrhage</u> (c) <u>MULTIPLE Myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>November 17, 1960</u> to <u>May 17, 1961</u> that (I) saw the deceased alive on <u>May 17, 1961</u> and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Jack Crowell</u> 22c. PHYSICIAN'S NAME (Type) <u>JACK CROWELL</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>2025 Eye St. N.W. Wash., D.C.</u>		22b. DATE SIGNED <u>May 17, 1961</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 22, 1961</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
23d. LOCATION (City, town or county) <u>Fort Meyer</u>		23e. (State) <u>Va</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Artzins Funeral Home</u>			
24a. ADDRESS <u>389 R.I. Ave N.W.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
DATE <u>MAY 19 '61</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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